

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7428

07359

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 mos. 2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Sam</u> Last <u>Badrich</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 6, 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min.		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith &amp; Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Serbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Badrich</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-6801</u>		17. INFORMANT Address <u>Mrs. Geo. S. Badrich 307 Vista St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of primary</u> <u>153.3</u> DUE TO <u>rectal sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rectal sigmoid colon</u> DUE TO (c) <u>Rectal sigmoid colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstruction of Central nervous system &amp; lymphatics</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1960</u> to <u>June 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 26, 1960</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L. L. Packard</u> M.D.				22b. DATE SIGNED <u>6/28/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packard MD</u>				22d. ADDRESS <u>145 W. Washington St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 29, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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**MARYLAND**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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07360

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
				f. STREET ADDRESS <b>421 W FRANKLIN STREET</b>			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>VAUGHN</b> Last <b>BALDWIN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 7 1960</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOHN R BALDWIN</b>				14. MOTHER'S MAIDEN NAME <b>PAULINE STUM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN R BALDWIN HAGERSTOWN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>773.5</b> IMMEDIATE CAUSE (a) <b>Perinatal Twin Birthwt 3'10"</b> DUE TO <b>Pulmonary Hyaline Membrane</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 Days</b> (c) <b>3 Days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/7/60</b> 19 to <b>6/10/60</b> 19, that (I) (we) last saw the deceased alive on <b>6/10/60</b> 19, and that death occurred <b>6/11/60</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ralph F. Young</b>				22b. DATE SIGNED <b>6/11/60</b>		22c. PHYSICIAN'S NAME (Typed) <b>RALPH F YOUNG M D</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>6/11/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 20 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
24. FUNERAL HOME <b>Shaver in Rouser</b>				ADDRESS <b>HAGERSTOWN MARYLAND</b>			

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TO HOSPITAL

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the original certificate.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

7378

07361

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float:right">b. COUNTY <b>WASHINGTON</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>40 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>874 FREDERICK STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEILA</b> Middle <b>DAISY</b> Last <b>BARBER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 15 1896</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>FRANKLIN POTTER</b>				14. MOTHER'S MAIDEN NAME <b>ALMA BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>SCOTT A BARBER</b> Address <b>HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>  <b>5 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>D.C.</u> 19 <u>57</u> to <u>June 8</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>60</u> and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <i>B B Kneisley</i>				22b. DATE SIGNED <b>June 10, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>B B KNEISLEY M D</b>				22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S NAME (Type) ADDRESS <i>Charles W. Roush</i> <b>HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JUN 13 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

MEDICAL CERTIFICATION

file State Bureau of Health Statistics, Baltimore, Md., and at City, State, and County Health Departments, and at City, State, and County Health Departments, and at City, State, and County Health Departments.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 5-59

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7379

CERTIFICATE OF DEATH

07362

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SHARON LYNN BARNHART</u>				4. DATE OF DEATH <u>JUNE 7 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1960</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HENRY BARNHART</u>				14. MOTHER'S MAIDEN NAME <u>PATSY ANN GORDON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Henry Barnhart</u>		18. ADDRESS <u>615 Elizabeth Ave Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Summerville</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Overeating</u> DUE TO <u>Exhaustion</u> (c) <u>Exhaustion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1960</u> to <u>June 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1960</u> , and that death occurred at <u>—</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis G. Graff, M.D.</u>				22b. DATE SIGNED <u>6-8-60</u>		22c. PHYSICIAN'S NAME (Type) <u>LOUIS G. GRAFF, M.D.</u>	
22d. ADDRESS <u>119 E. ANTIETAM ST. HAGERSTOWN, MD.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Mennich - Greencastle, Penna.</u>				25a. REC'D BY REGISTRAR <u>JUN 10 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 7380 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

07363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CLEARSPRING</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>1 R#1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE OMAR BLAIR</u>		4. DATE OF DEATH Month Day Year <u>June 27, 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1895</u>
9. AGE (In years last birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. construction</u>	
11. BIRTH PLACE (State or foreign country) <u>MERCERSBURG, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WARD BLAIR</u>		14. MOTHER'S MAIDEN NAME <u>MARIA SHAFFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>205-09-944</u>	
17. INFORMANT <u>MRS. ELSIE S. Blair, Clearspring Ind., P. 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>502.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary emphysema</u> DUE TO <u>chronic bronchitis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days -</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/23, 1960</u> , to <u>6/26, 1960</u> , that I last saw the deceased alive on <u>6/26, 1960</u> , and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u>		ADDRESS (Street, city or town, state) <u>154 West Washington St.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M. D.</u>		DATE SIGNED <u>June 27, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG, PA. P. 2</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Luning</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
ADDRESS <u>MERCERSBURG, PA.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7381

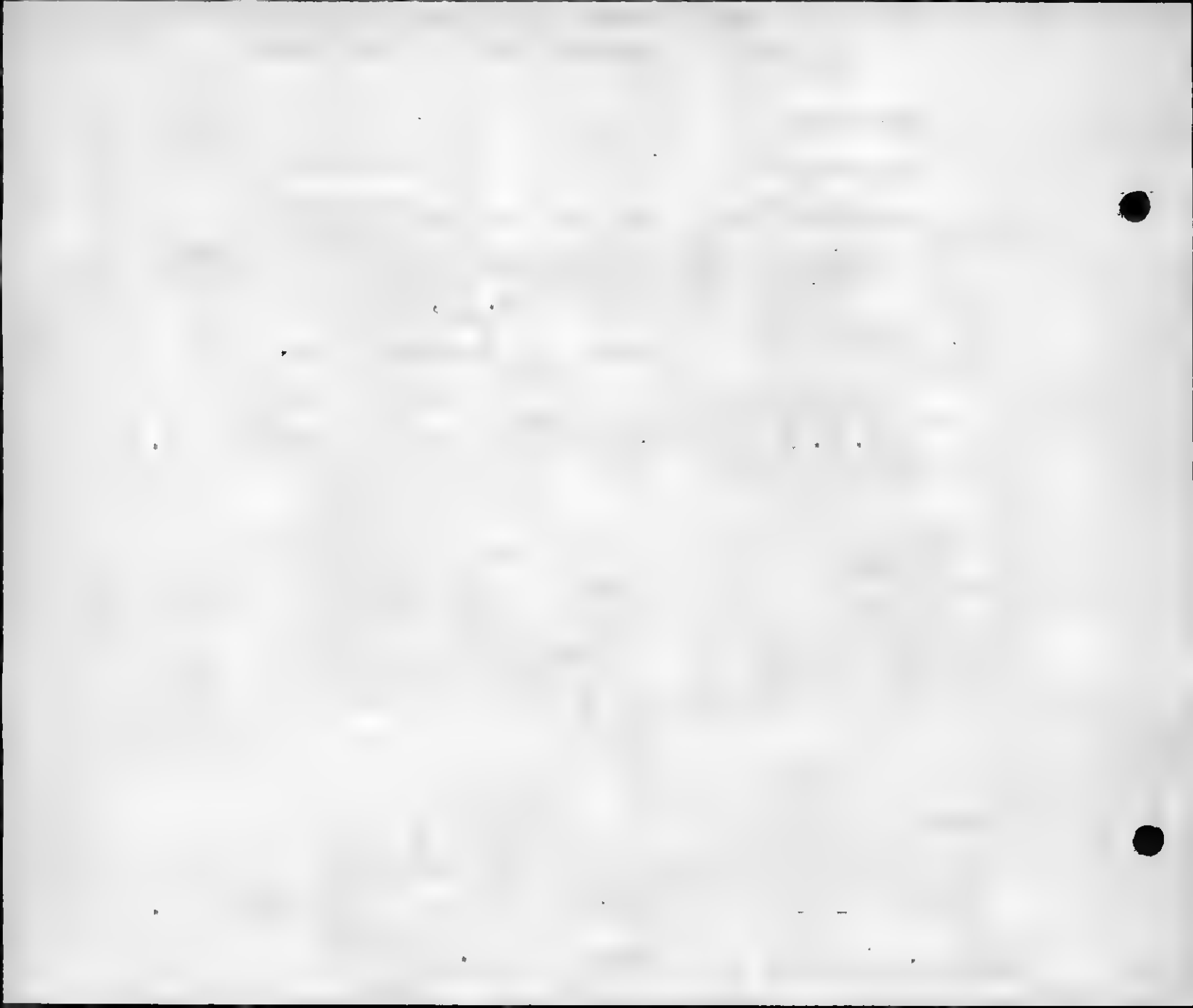
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Birm 265 6-22-60 at

07364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Academy Hill</b>		/d. STREET ADDRESS <b>Academy Hill</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lewis Mc Kay Boward</b>		4. DATE OF DEATH approx. Month <b>June</b> Day <b>3</b> , Year <b>1960</b> <b>Unknown</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emanuel Boward</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Springer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. L 215-14-2503</b>	
17. INFORMANT <b>Fred Boward</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure - Probable</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Known</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Cirrhosis Liver &amp; Chronic Alcoholism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Not Known</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No Known Injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto III, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/12/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-17-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7382

## CERTIFICATE OF DEATH

07365

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>11 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>117 E. High Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Grafton Finley BRASHEARS</b>				4. DATE OF DEATH Month <b>6</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29 1888</b>	
9. AGE (in years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months <b>2</b> Days <b>9</b>		IF UNDER 24 HRS: Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Assembler</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Refrigeration</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>							
13. FATHER'S NAME <b>Thomas Brashears</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Peterman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219 05 2295</b>		17. INFORMANT <b>Mrs. Ida Brashears</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> <b>332 X</b> DUE TO <b>cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <b>cerebral arteriosclerosis</b> (c) <b>generalized arteriosclerosis, Secubiti.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>11 weeks</b> <b>unknown.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis, Secubiti.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1960</b> to <b>June 6, 1960</b> that (I) (we) last saw the deceased alive on <b>June 6, 1960</b> and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Young E. Chun,</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>June 6, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Young E. Chun,</b>				22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>			
23a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 9-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf Williamsport, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 9 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO HOSPITAL: may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/59

7434

MARYLAND STATE BOARD OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

07366

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAUGANSVILLE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAUGANSVILLE, MD.</u>				e. STREET ADDRESS <u>MAUGANSVILLE, MD.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>G.</u> Last <u>BURKHOLDER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/1873</u>	9. AGE (In years last birthday) <u>87</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MAUGANSVILLE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN E. HORST</u>				14. MOTHER'S MAIDEN NAME <u>ANNA GOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edgar H. Burkholder -</u>		Address <u>RD 2 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>June 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1960</u> and that death occurred at <u>251A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington St. Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MILLERS MENNONITE CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>Near Hagersburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Penna.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneisley</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7383

## CERTIFICATE OF DEATH

Reg. Dist. No. 07367

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. LODDON, PA.</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		d. STREET ADDRESS <u>101 BELVIEW AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <del>DECEASED</del> (Type or print) <u>Charles H. Byers</u>		4. DATE OF DEATH <u>June 5, 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RICHMOND FURNACE, PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANKER BYERS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HAISTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>204-03-7701</u>	
17. INFORMANT <u>Clyde E. Byers</u>		Address <u>St. Thomas, PA., R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Arteriosclerotic Heart D.</u> DUE TO (c) <u>25 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Not seen alive</u> to <u>2:15 PM</u> , that I last saw the deceased <u>at home 2 weeks ago</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binfarf</u>		ADDRESS (Street, city or town, state) <u>1135 Patmoe AVE</u>	
PHYSICIAN'S NAME (Type) <u>Richard T. Binfarf</u>		DATE SIGNED <u>5 June 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PENGER HILL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>FT. LODDON, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Hunsinger</u>		ADDRESS <u>Mercersburg, Pa.</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07368  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Charlton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Falling Waters RFD #1</u>	
c. LENGTH OF STAY IN 1b <u>30 min.</u>		d. STREET ADDRESS <u>Falling Waters RFD #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) <u>Nardi</u> First <u>Leo</u> Middle <u>Ceravalo</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 1932</u>
9. AGE (In years last birthday) <u>27</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Falling Waters RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dominick Ceravalo</u>		14. MOTHER'S MAIDEN NAME <u>Julia Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>234 54 9897</u>	
17. INFORMANT <u>Mrs. Kathleen Jones</u>		Address <u>Falling Waters W. Va. RFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell from boat into water while fishing.</u>		20c. TIME OF INJURY Month, Day, Year <u>6/26/1960</u> Hour <u>7</u> m. <u>2</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River - Mr. Charlton Wash. Md</u>	
20f. (City or town) <u>Mr. Charlton</u>		20g. (County) <u>Wash.</u>	
20h. (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Edward W. Diffen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Diffen</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/28/60</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 29-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Marlowe W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leaf</u>		ADDRESS <u>7000 W. Washington St. N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





7429

## CERTIFICATE OF DEATH

Reg. Dist. No.

07369

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Margaret Clipper</u>		4. DATE OF DEATH Month Day Year <u>June 2 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1861</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hessong</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Mrs. A. Toms (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory collapse</u> 7-44X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Cerebral</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fx hip</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>1 mo</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>June 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>4:48</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ME Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>6-3-60</u>	
PHYSICIAN'S NAME (Type) <u>ME Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leitersburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leitersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Smithsburg, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

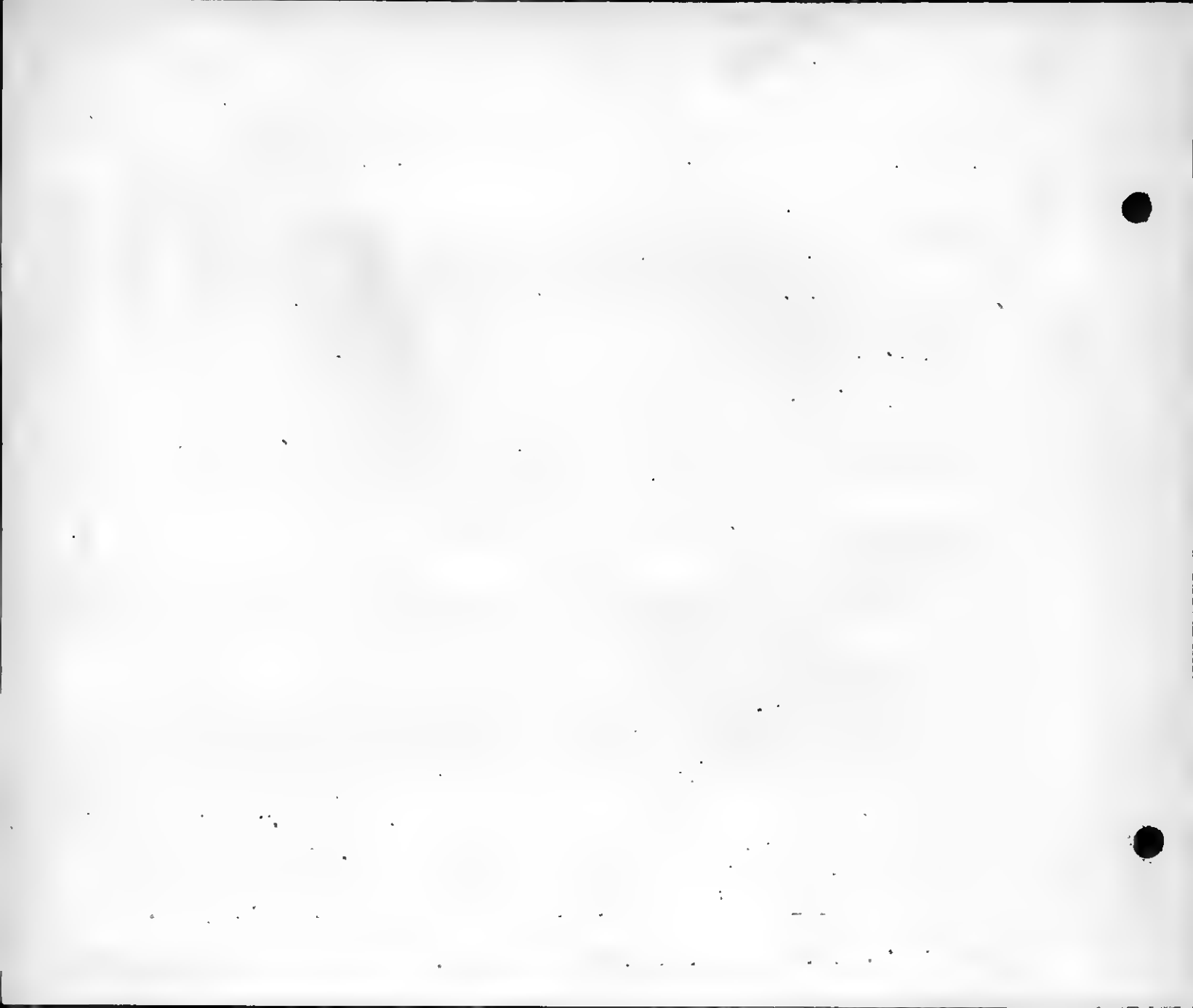
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7384

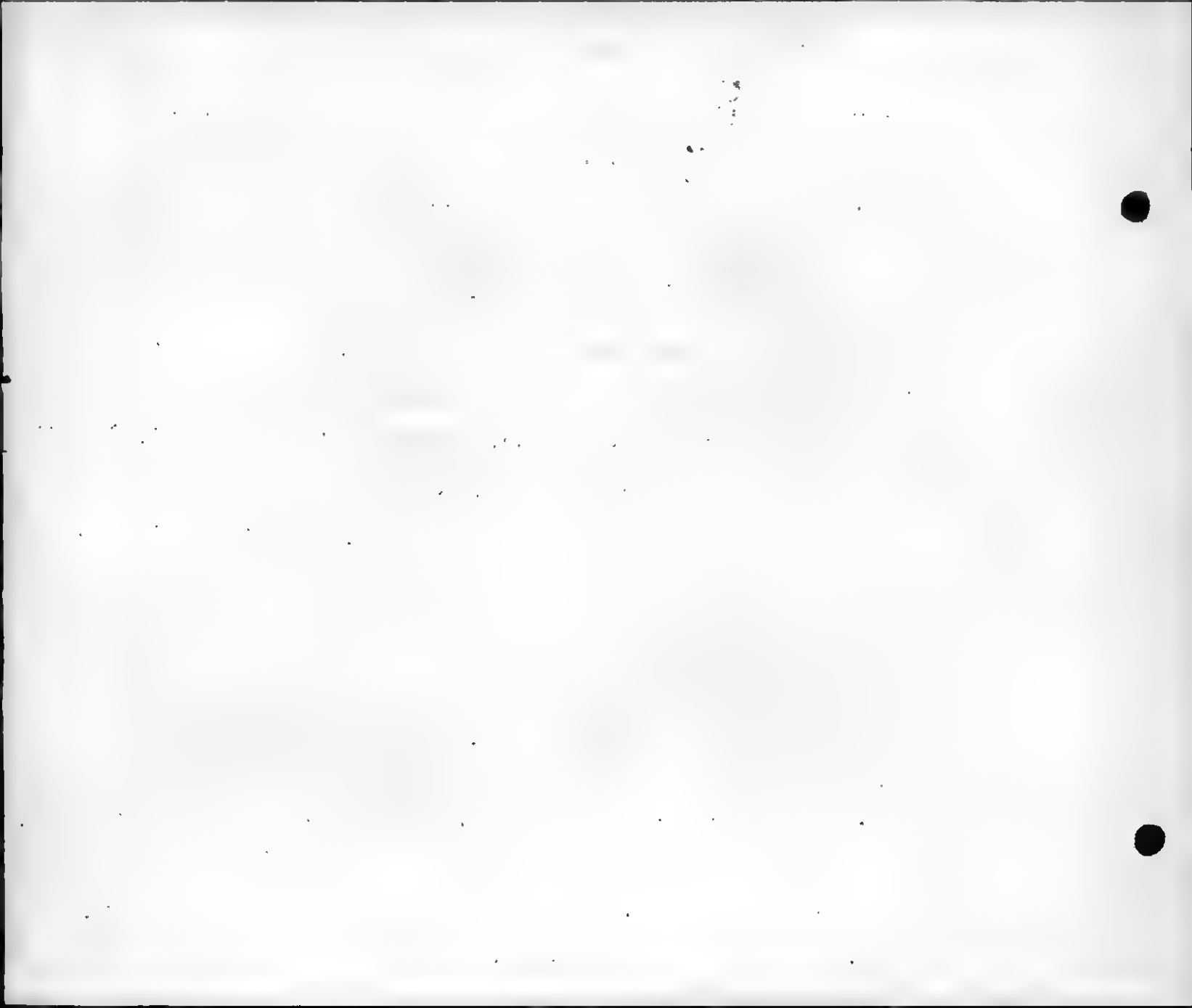
## CERTIFICATE OF DEATH

Reg. Dist. No.

07370

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JENNINGS</b> Middle <b>BRYAN</b> Last <b>CONSTABLE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 31, 1895</b>		9 AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Inkerman, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas F. Constable</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Shadwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>224-10-9465</b>		INFORMANT <b>Mrs. J. B. Constable 133 Fairground Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerotic Heart D.</b> DUE TO (c) <b>Sudden</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1960</b> , to <b>June 10, 1960</b> , that I last saw the deceased alive on <b>June 10, 1960</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Funkstown, Md.</b> DATE SIGNED <b>6-11-60</b>							
ACTUAL SIGNATURE <b>SIDNEY ROVENSTEIN</b>		PHYSICIAN'S NAME (Type) <b>SIDNEY ROVENSTEIN Funkstown, Md.</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

Wm. G. Hunt



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

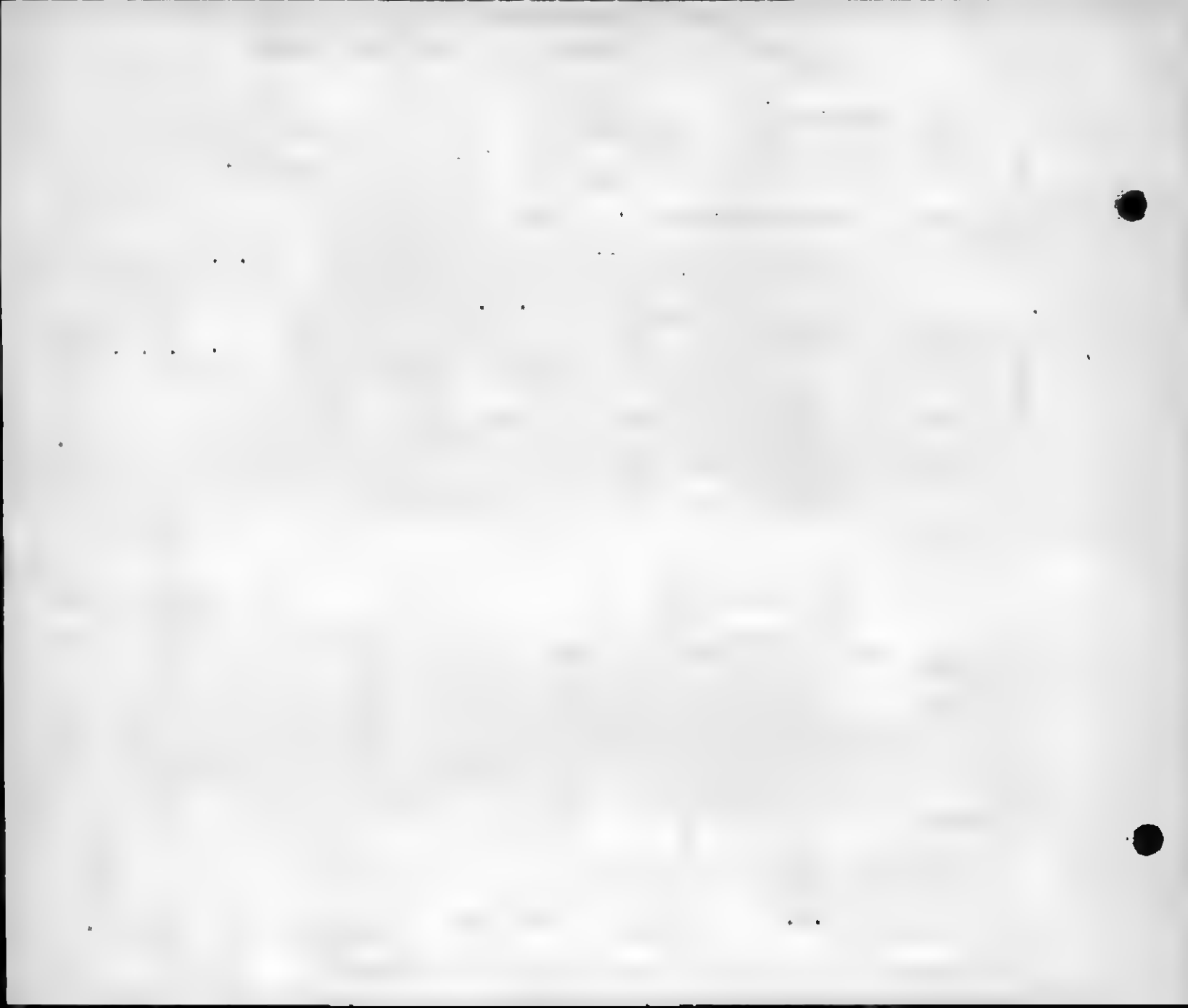
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 71

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Md</b>		c. LENGTH OF STAY IN Td	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Little Pool Near Hancock Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Sparr</b> Last <b>Dickerhoff</b>		4. DATE OF DEATH Month <b>6.5.</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.23.1922</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months <b>37</b> Days <b>37</b>	11. IF UNDER 24 HRS. Hours <b>37</b> Min. <b>37</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elmer E Dickerhoff</b>		14. MOTHER'S MAIDEN NAME <b>Bessie E Heller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes World War 2</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Ann M Dickerhoff</b>		Address <b>Rural 1 Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Truck to Rescue fellow fireman</b>	
20c. TIME OF INJURY Month, Day, Year <b>3.35 am 6-5 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Condo</b>		20f. (City or town) (County) (State) <b>Hancock Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>A. E. W. L. I. T. O. E.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>A. E. W. L. I. T. O. E.</b>		DATE SIGNED <b>6/5/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6.8.60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hansrud &amp; Shone</b>		ADDRESS <b>Hancock Md</b>	
24a. REC'D BY REGISTRAR <b>JUN 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Hanna</b>	

MEDICAL CERTIFICATION





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE-16

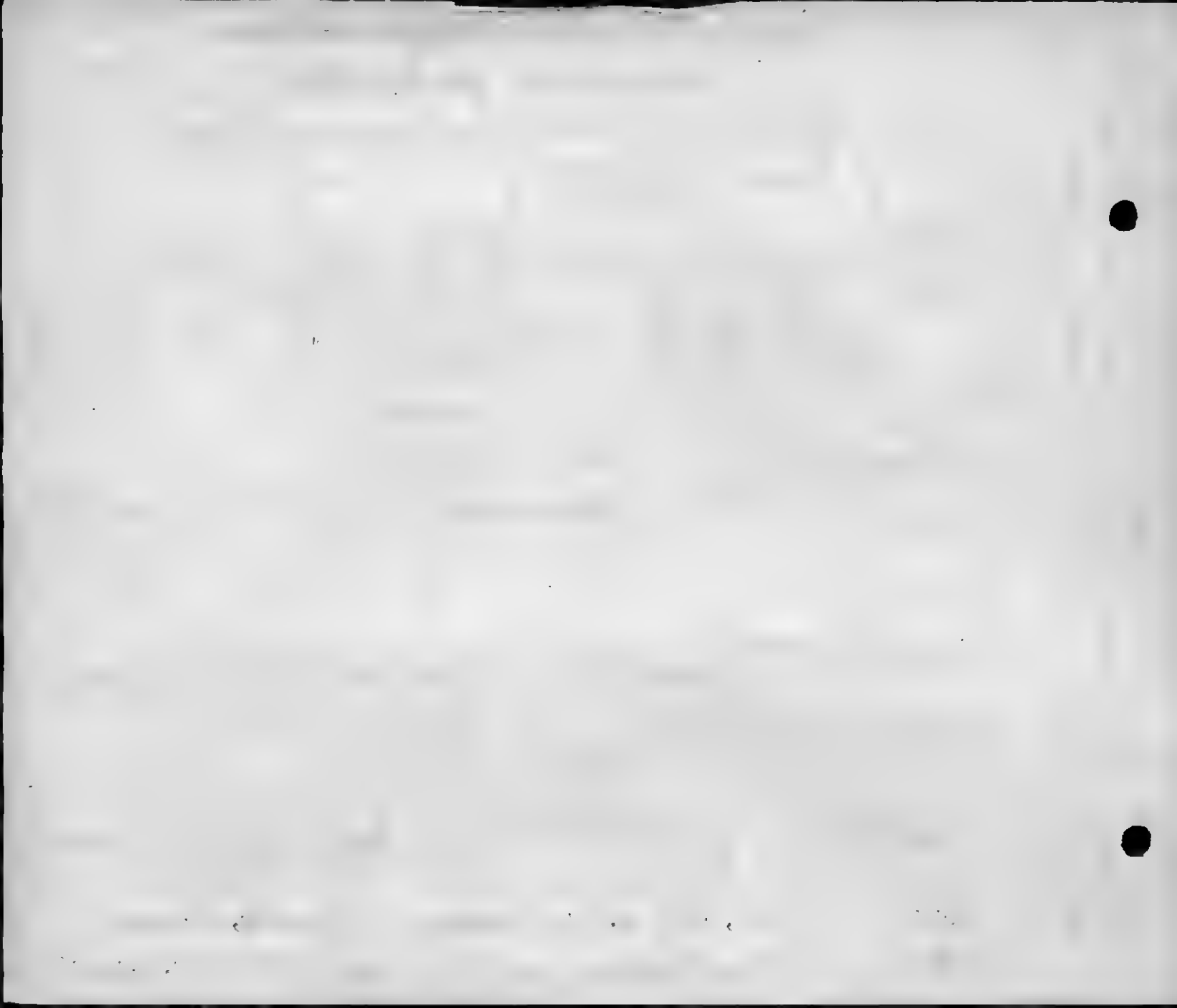
## CERTIFICATE OF DEATH

07372

Reg. Dist. No. ....

7437

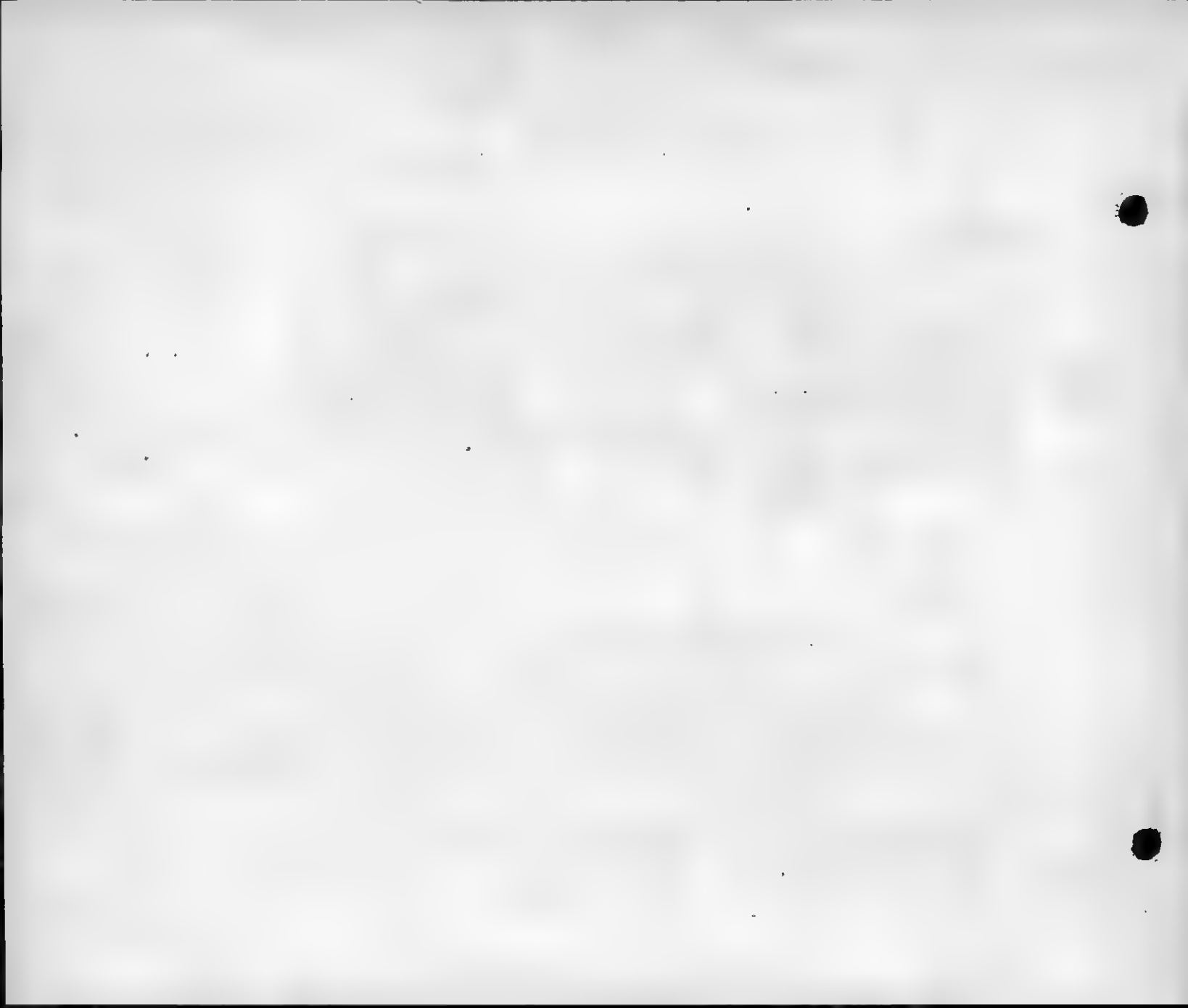
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>7 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Church Home</u>				STREET ADDRESS (If rural give location) <u>14 East 5th St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Anna</u> (Middle) <u>mary</u> (Last) <u>Dieterich</u>				(Month) <u>June</u> (Day) <u>30</u> (Year) <u>1960</u>			
<b>5. SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>single</u>	<b>8. DATE OF BIRTH</b> <u>Oct 21, 1885</u>		<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frederick</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Justus Dieterich</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Catherine Zerlach</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>  </u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Wagner, R#2</u> <u>Frederick, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>17. IMMEDIATE CAUSE (A)</b> <u>Cardiovascular disease</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 hr.</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Carcinoma of the breast</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>DUE TO</b>			
<b>(C)</b>							
<b>18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct 1959</u> , <b>to</b> <u>June 30, 1960</u> , <b>that I last saw the deceased alive on</b> <u>June 29, 1960</u> , <b>and that death occurred at</b> <u>7:20 A.M.</u> <b>on</b> <u>June 30, 1960</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Lain Hall</u>				<b>DATE SIGNED</b> <u>June 6, 1960</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>July 2, 1960</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Frederick, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Jul 6 '60</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Charles S. Kimes</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert E. Bailey</u>			
<b>DATE</b>				<b>ADDRESS</b> <u>Frederick, Maryland</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

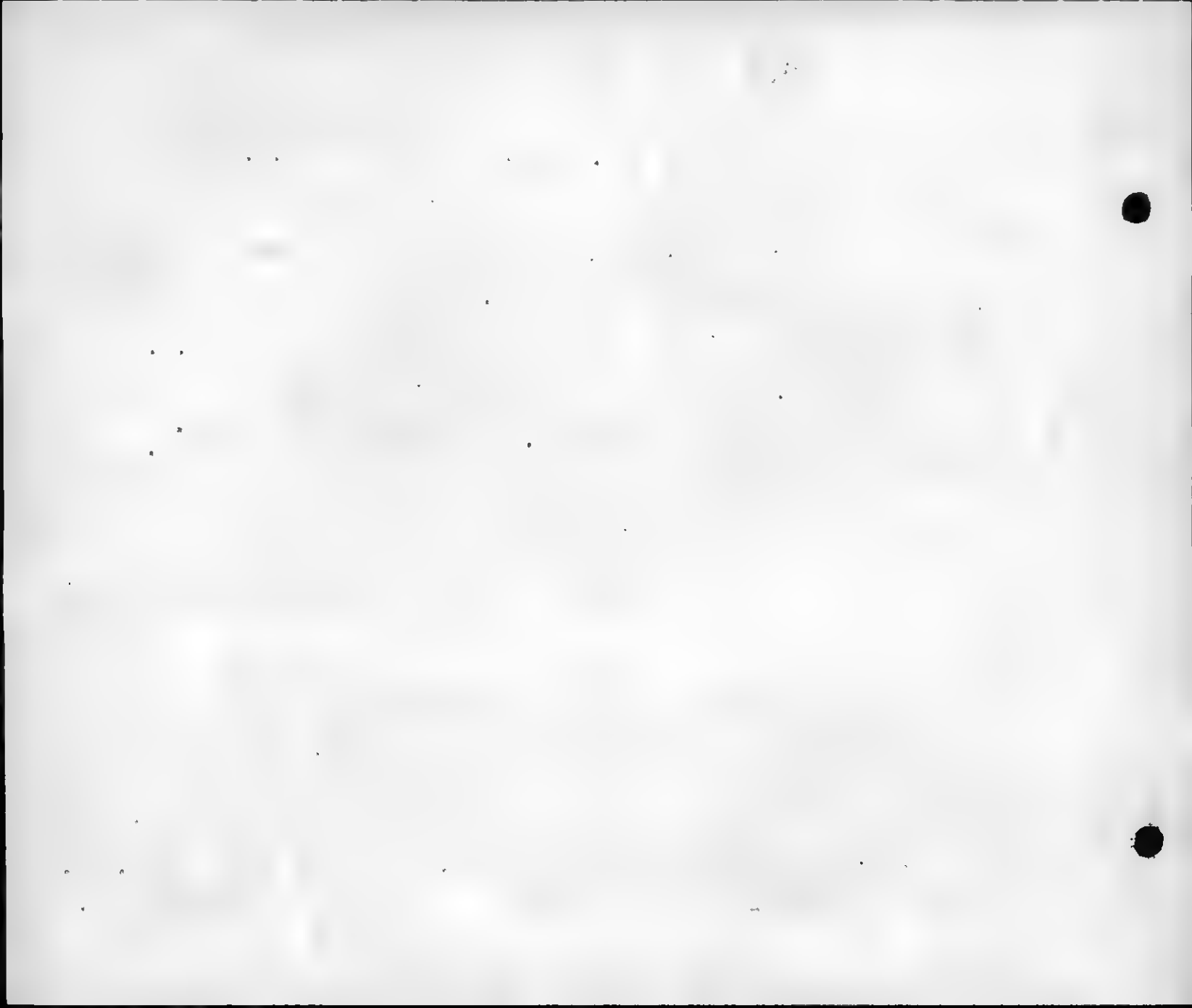
Item 18 Film 2077430									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07373									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bear Of 24 Potomac Street</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b> d. STREET ADDRESS <b>Bear Of 24 Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Melton</b> Middle <b>Samuel</b> Last <b>Ditlow</b>					4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1960</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>83</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Power Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>William Ditlow</b>					14. MOTHER'S MAIDEN NAME <b>Mary Norris</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 09 9010</b>		17. INFORMANT <b>Mary E. Ditlow</b>		820 Washington Ave. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis with cortical necrosis</b> DUE TO (b) <b>Pyelonephritis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Benign prostatic hyperplasia - total urinary retention</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>adenocarcinoma prostate</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>o. m.</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <b>6/29/60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hiverview Cemetery</b>		22d. LOCATION (City, town, or county) <b>Williamsport</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kline</b>					24a. REC'D BY REGISTRAR <b>DATE JUL 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		



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7433  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07374

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown RFD #3</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown R.F.D #3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Ridge Drive</b>		d. STREET ADDRESS <b>Oak Ridge Drive</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Camilla</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs		IF UNDER 1 YEAR: Months <b>4</b> Days <b>1</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crop Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Lloyd C. Weaver</b>	
14. MOTHER'S MAIDEN NAME <b>Fannie Mc Namee</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215 36 7081</b>		17. INFORMANT <b>Mr. Carl Dorsey Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic heart disease 10 years</b> DUE TO (c) <b>Toxic thyroiditis 10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1934</b> to <b>6.19.60</b> , that (I) (we) last saw the deceased alive on <b>6.19.60</b> , and that death occurred at <b>3. P.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Earl Young</b>		22b. DATE SIGNED <b>6.20.60</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. Earl Young M.D.</b>		22d. ADDRESS <b>148 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 21-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Near Tilghmanton Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Long Williams, Port</b>		25a. REC'D BY REGISTRAR <b>Arthur L. Kraus</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		DATE <b>JUN 22 '60</b>	





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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7385

CERTIFICATE OF DEATH

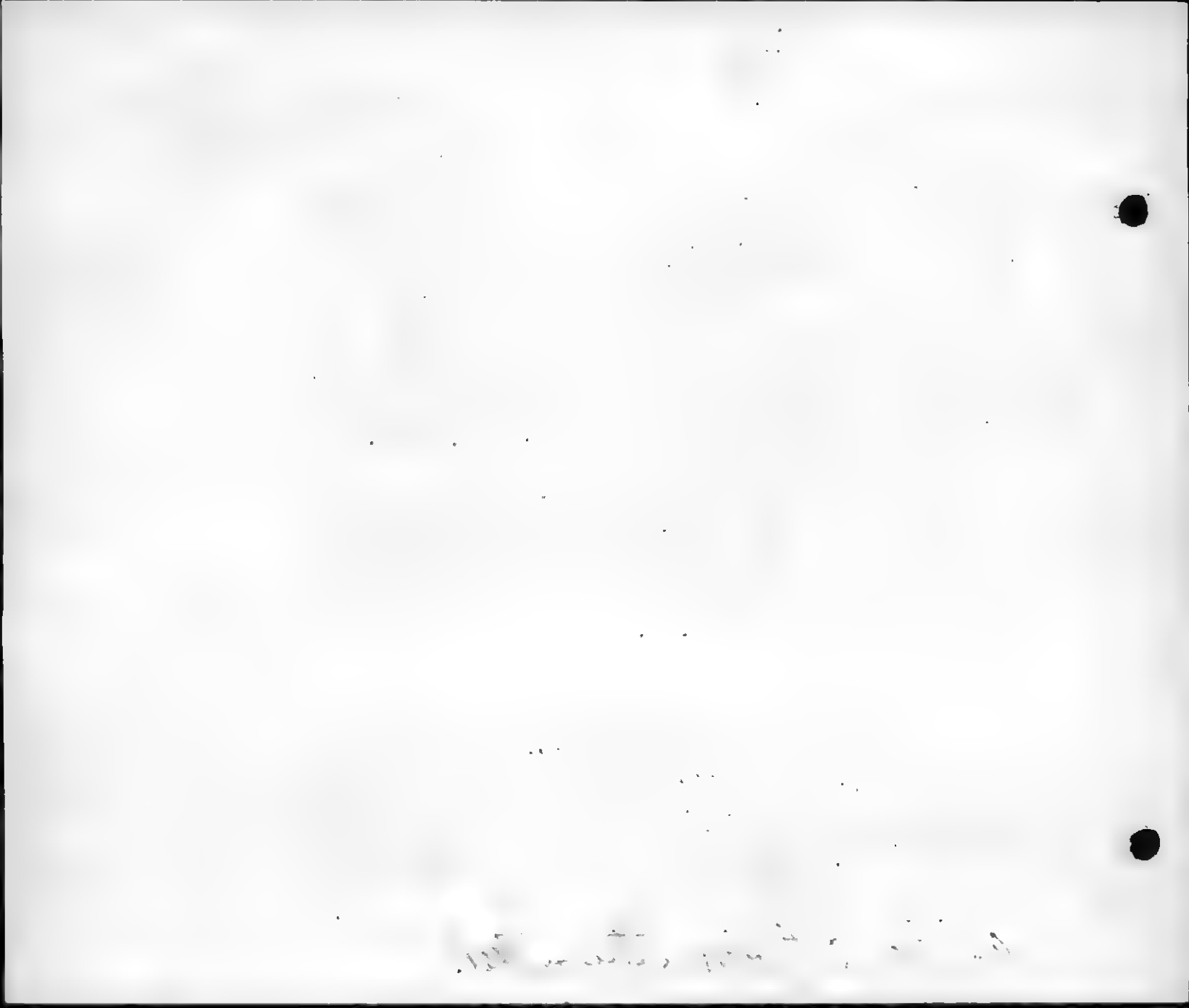
Reg. Dist. No.

07375

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write full name of place, street, and town) <b>HAGERSTOWN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>218 WOODPOINT AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LULU First CATHERINE Middle DUTROW Last</b>		4. DATE OF DEATH <b>JUNE 18 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/1881</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM D. ENGLEBERGER</b>	
14. MOTHER'S MAIDEN NAME <b>ADELLA M. MILLER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT Address <b>MILLARD G. DUTROW (SAME AS ITEM #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM-INAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 10, 1960</b> to <b>June 18, 1960</b> , that I last saw the deceased alive on <b>June 17, 1960</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.A. Bell</b>		ADDRESS (Street, city or town, state) <b>119 North Potomac St. 6-18-60</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		Hagerstown, Maryland.	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/20/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>FREDERICK MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Norman, Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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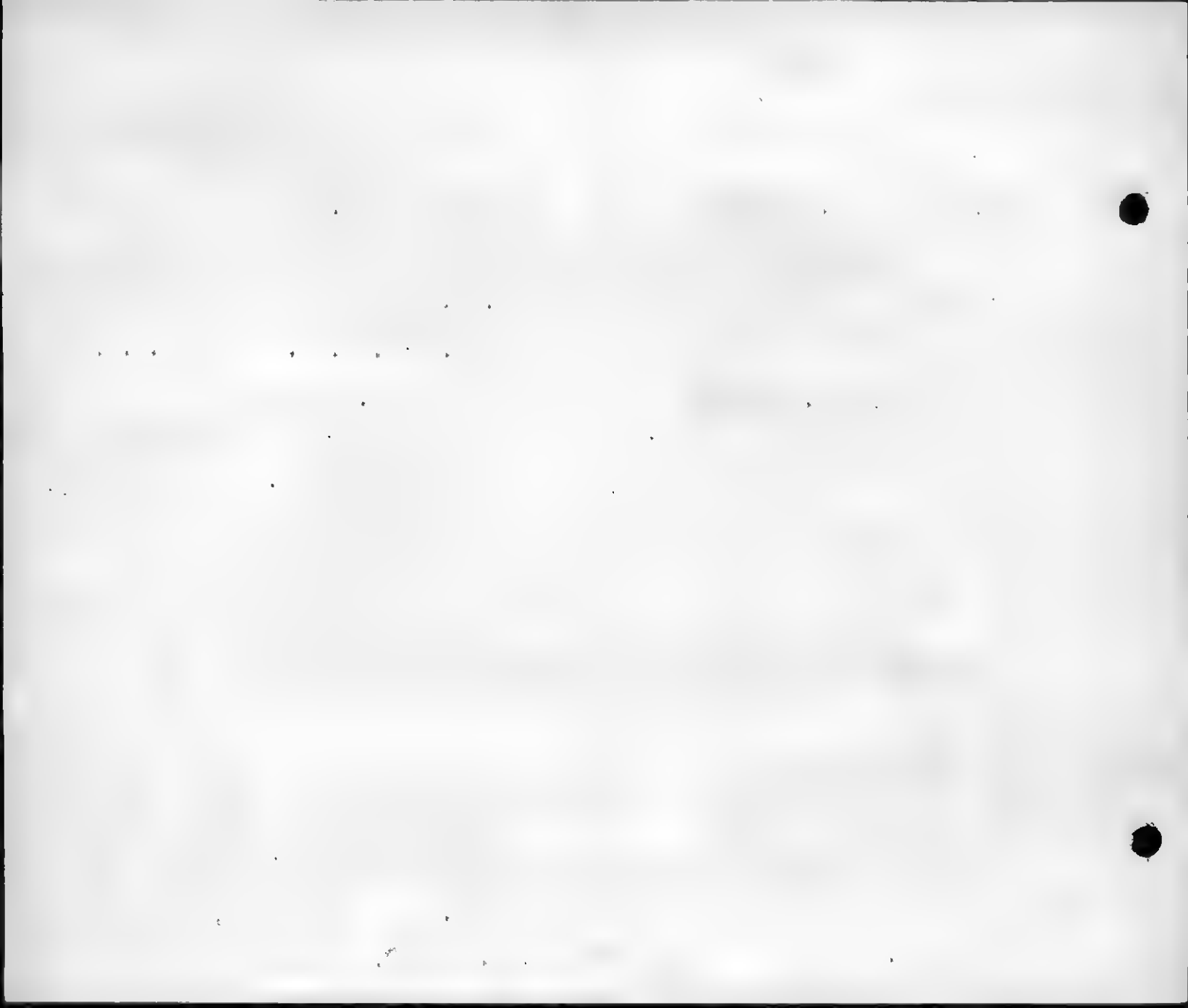
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7386

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07376

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>855 Summit Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Magdalene Caroline Eiler</b>		4. DATE OF DEATH <b>June 1 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR <b>1</b> Months <b>1</b> Days <b>19</b> Hours <b>60</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hag. Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles E. Lokstine</b>		14. MOTHER'S MAIDEN NAME <b>Flora A. Stockslager</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Murray E Eiler</b>		Address <b>855 Summit Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of rt int. carotid artery</b> DUE TO (b) <b>Atherosclerosis of vessel</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 5 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>30 May 1960</b> to <b>1 June 1960</b> , that (I) (we) last saw the deceased alive on <b>1 June 1960</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Elden S. Hoachlander</b> M.D.		22b. DATE SIGNED <b>6/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Elden S. Hoachlander</b>		22d. ADDRESS <b>Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 6 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Christus S. Howard</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

07377

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hawn Convalescent Home</b>		d. STREET ADDRESS <b>344 S. Potomac Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Ellen</b> Last <b>Eyler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1879</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>New Oxford, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Sadler</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Herman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Kathryn C. Garner</b>		Address <b>344 S. Potomac, St. Waynesboro, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Cerebrovascular Disease</b> DUE TO (c) <b>10 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1960</b> to <b>June 26, 1960</b> that I last saw the deceased alive on <b>June 25, 1960</b> and that death occurred at <b>6:12 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa.</b> DATE SIGNED <b>27 June 60</b>			
ACTUAL SIGNATURE <b>Robert A. Thupf</b>		PHYSICIAN'S NAME (Type) <b>M.D. Blue Ridge Summit, Pa.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial June 29, 1960</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Orthur S. Kraus</b>	



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7440

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

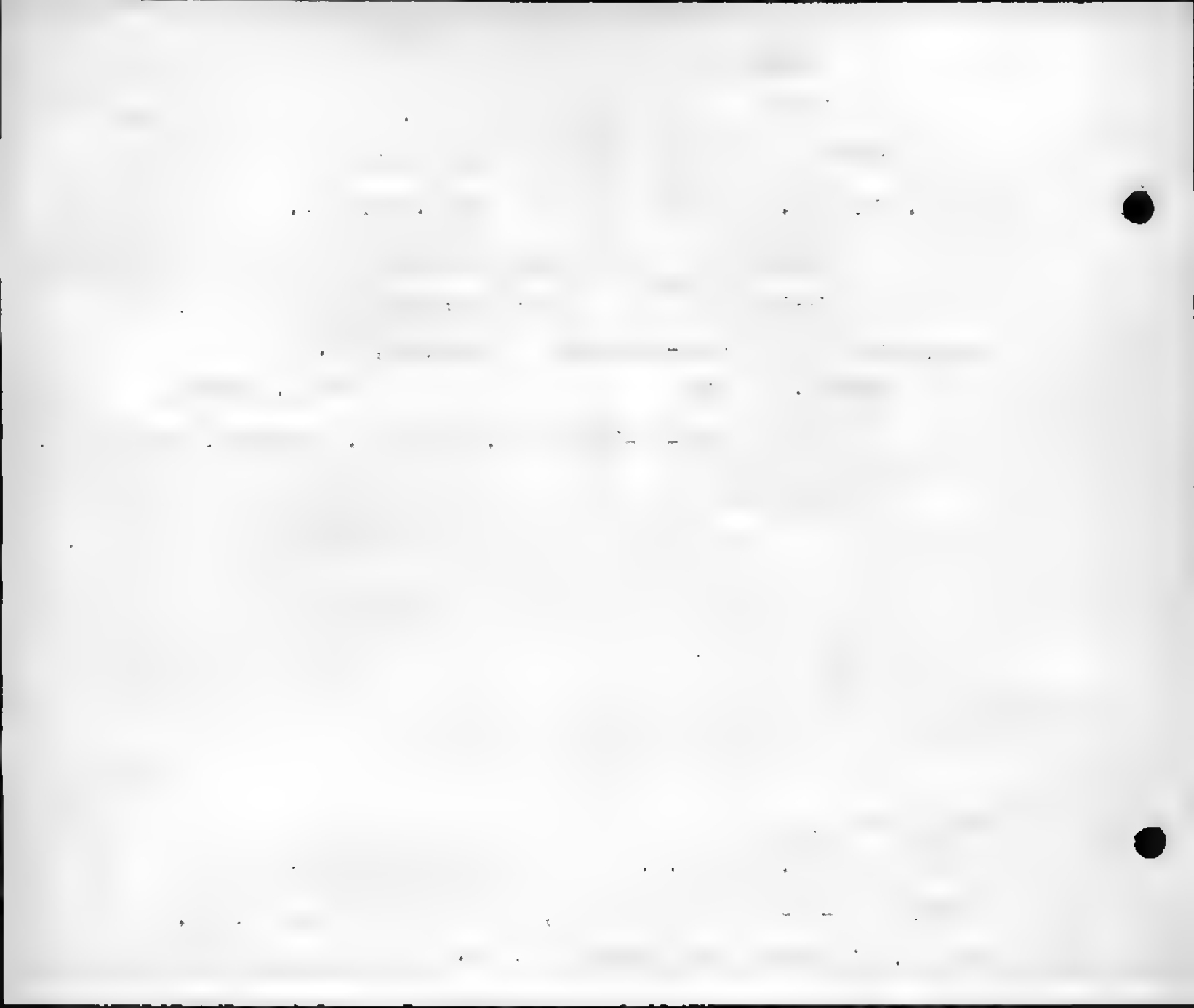
CERTIFICATE OF DEATH

07378  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b> c. LENGTH OF STAY IN 1b <b>45 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 W. Main St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b> d. STREET ADDRESS <b>29 W. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Washington</b> Last <b>Ferguson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1880</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Ringgold, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John H. Ferguson</b>		14. MOTHER'S MAIDEN NAME <b>Anna B. Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-20-1832</b>	
17. INFORMANT <b>Mrs. Nannie M. Ferguson, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>10 Yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/10, 1954</b> to <b>6/15, 1960</b> that I last saw the deceased alive on <b>6/15, 1960</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>6/15/60</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-18-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





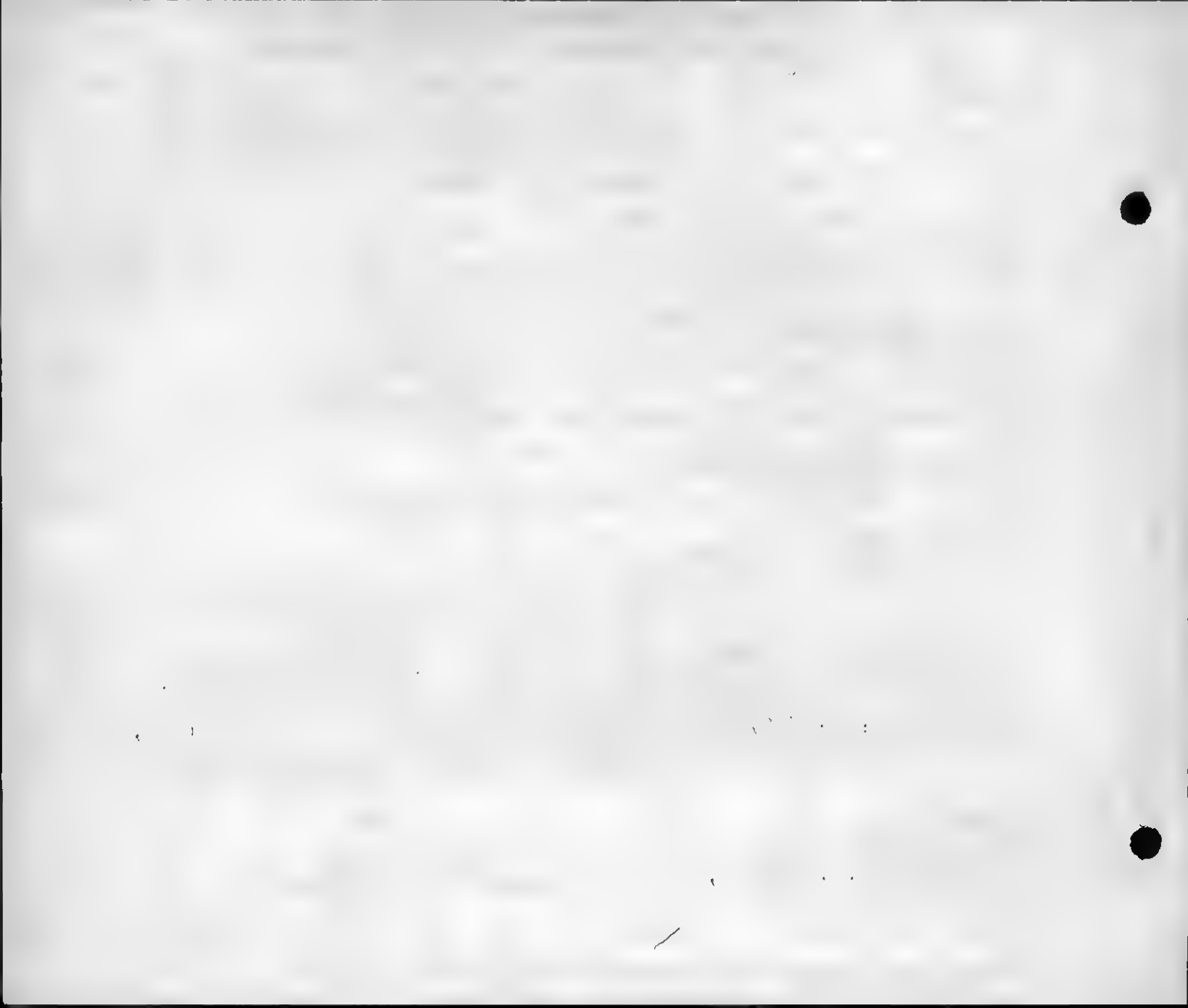
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07379  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>		7-5-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 miles west on Rt. 40</u>				d. STREET ADDRESS <u>1317 S. 4th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Florig, Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1934</u>		9. AGE (In years last birthday) <u>25</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lat operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles E. Florig</u>				14. MOTHER'S MAIDEN NAME <u>Kathleen Flora</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>106-28-5379</u>		17. INFORMANT <u>Charles E. Florig, 1317 S. 4th.</u>		Address <u>Chambersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>821X</u> <u>FRACTURED CERVICAL SPINE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>THROWN FROM MOTOR-CYCLE WHILE SPEEDING - HAG. SPEEDWAY</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>2:50</u> <u>6/12/60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.) <u>SPEEDWAY 6 MI. WEST OF HAGERSTOWN, MD</u>		20f. (City or town) (County) (State) <u>Chambersburg, Pa.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DR. E. W. DITTO, JR.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rougeaux Fun. Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 20 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7387

## CERTIFICATE OF DEATH

Reg. Dist. No.

07380

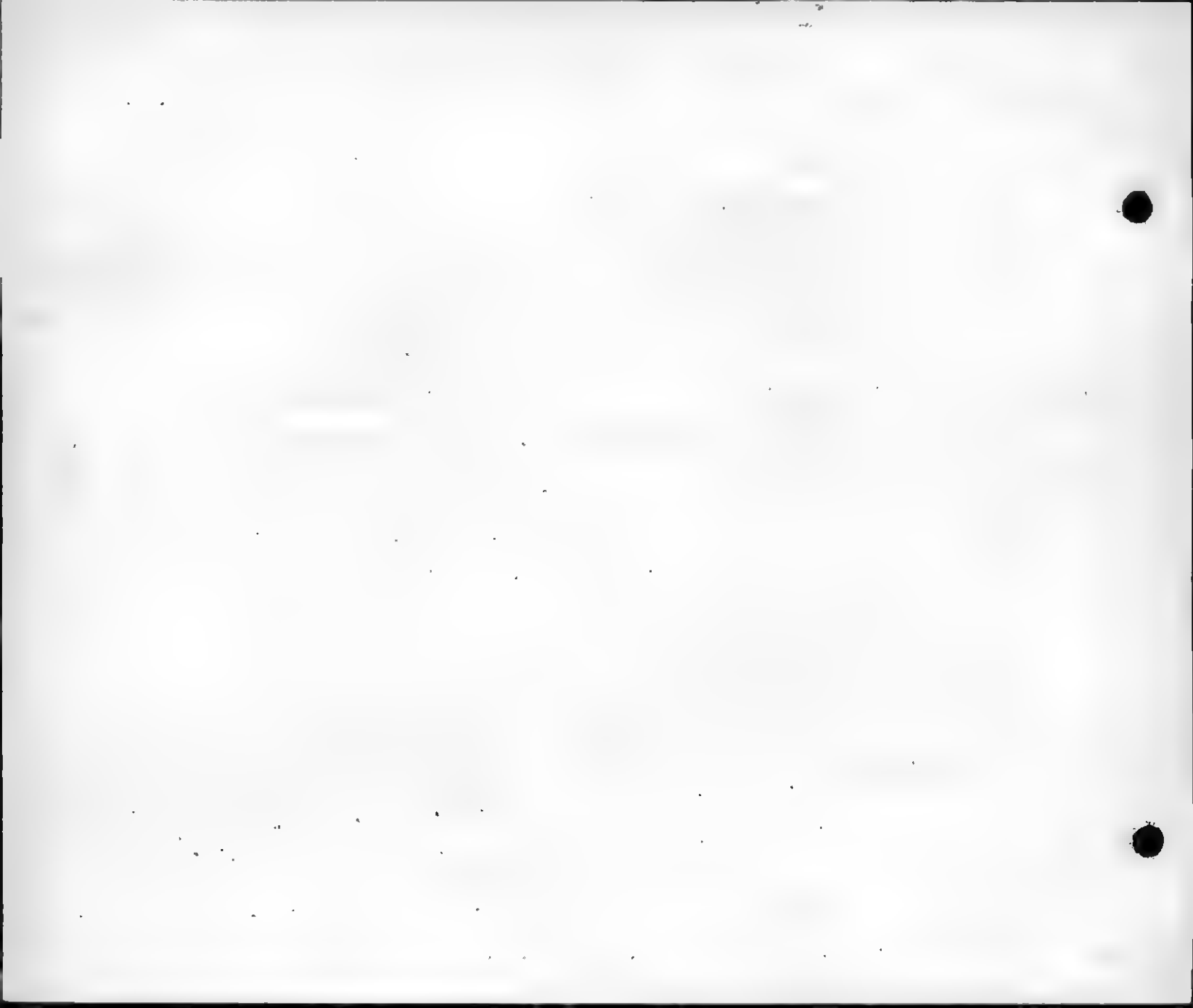
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leitersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ABNER</b> Last <b>FUNK</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>15</b> Hours <b>42</b> Min <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Houses etc.</b>	
11. BIRTHPLACE (State or foreign country) <b>Strasburg, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Funk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1921 - 1925</b>		16. SOCIAL SECURITY NO. <b>223-20-4153</b>	
17. INFORMANT <b>Mrs. Wm. A. Funk</b>		Address <b>Leitersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA and CONGESTION</b> DUE TO <b>Cor Pulmonale decompensated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>PULMONARY EMPHYSEMA, CHRONIC</b> DUE TO <b>PULMONARY EMPHYSEMA, CHRONIC</b> DUE TO <b>PULMONARY EMPHYSEMA, CHRONIC</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>10 YRS</b> <b>15 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 16</b> , 19 <b>60</b> , to <b>JUNE 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JUNE 20</b> , 19 <b>60</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above.		DATE SIGNED <b>6-22-60</b>	
ACTUAL SIGNATURE <b>E. R. Lardizabal</b> M.D.		ADDRESS (Street, city or town, state) <b>12 South Main St</b>	
PHYSICIAN'S NAME (Type) <b>E. R. Lardizabal, M.D.</b>		<b>Smithsburg Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 23, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

Under a n. Assumed name

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be re- by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

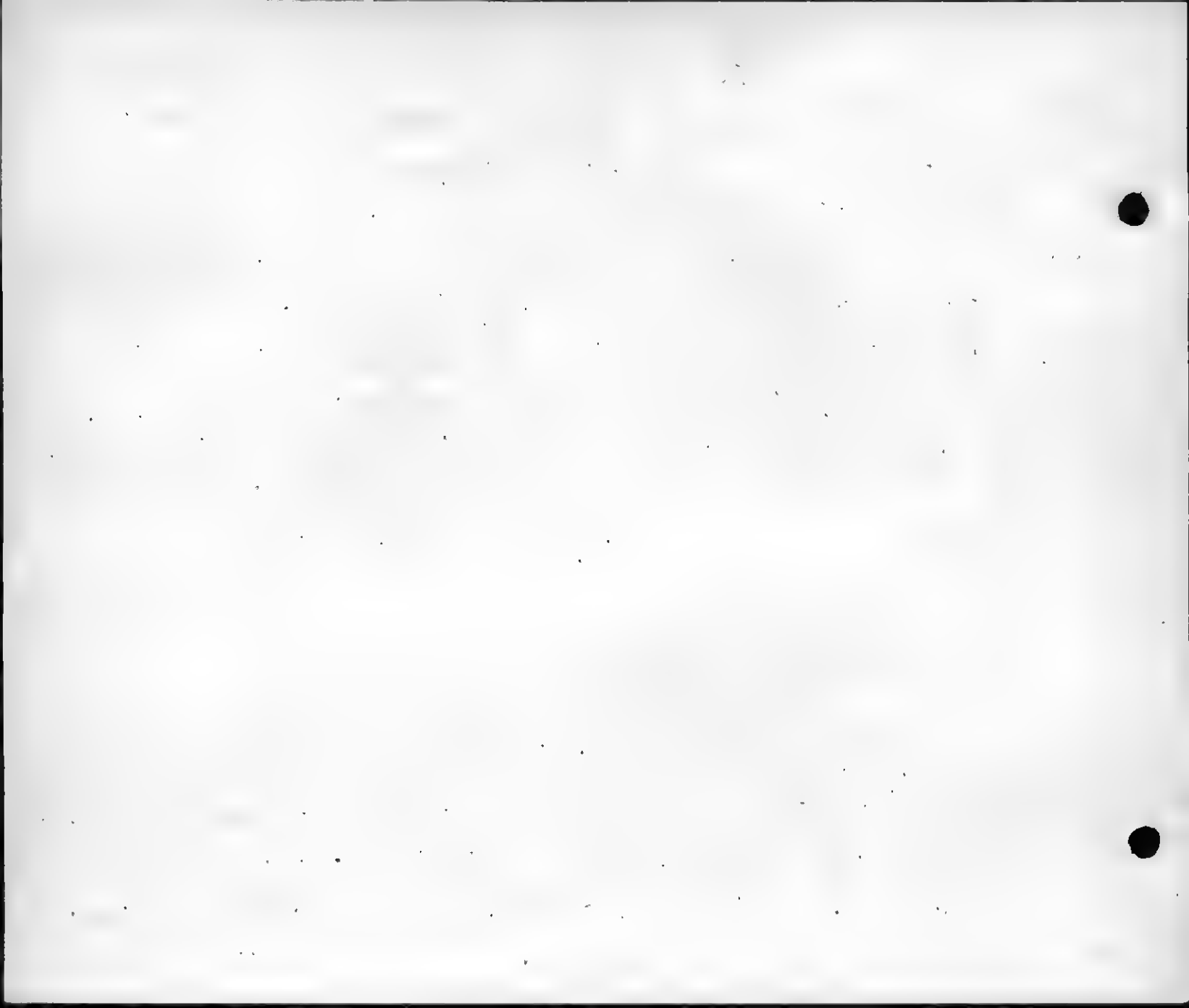
07381

7431

## CERTIFICATE OF DEATH

Reg. 100-106

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
f. STREET ADDRESS <u>420 South Potomac St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>K.</u> Last <u>Gearhart</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagers Town, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Martin J. Gearhart</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Welty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Arthur Eyer, 409 S. Potomac St., Waynesboro, Pa.</u>		Address <u>Waynesboro, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion EMyocardial infarct 420.1</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 24, 1960</u> to <u>June 13, 1960</u> that I last saw the deceased alive on <u>May 30, 1960</u> and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ME By Kit</u> M.D. <u>28 W Potomac</u>		DATE SIGNED <u>6-13-60</u>	
PHYSICIAN'S NAME (Type) <u>ME By Kit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Marlin Poe</u> ADDRESS <u>Waynesboro, Penna.</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawt</u>	



# 7388 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07382

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>Unknown</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>rear 518 Mitchell Ave</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>510 Salem Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN RAYMOND GLADHILL</b>				4. DATE OF DEATH Month Day Year <b>June 7 1960 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 20 1907</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles R. Gladhill</b>				14. MOTHER'S MAIDEN NAME <b>Linnie Eyerly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.#2</b>				16. SOCIAL SECURITY NO. <b>814-09-7667</b>		17. INFORMANT <b>Charles R. Gladhill</b> Address <b>510 Salem Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH <b>Recent</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) <b>Dr E W Dittto Jr</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4c may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7389

## CERTIFICATE OF DEATH

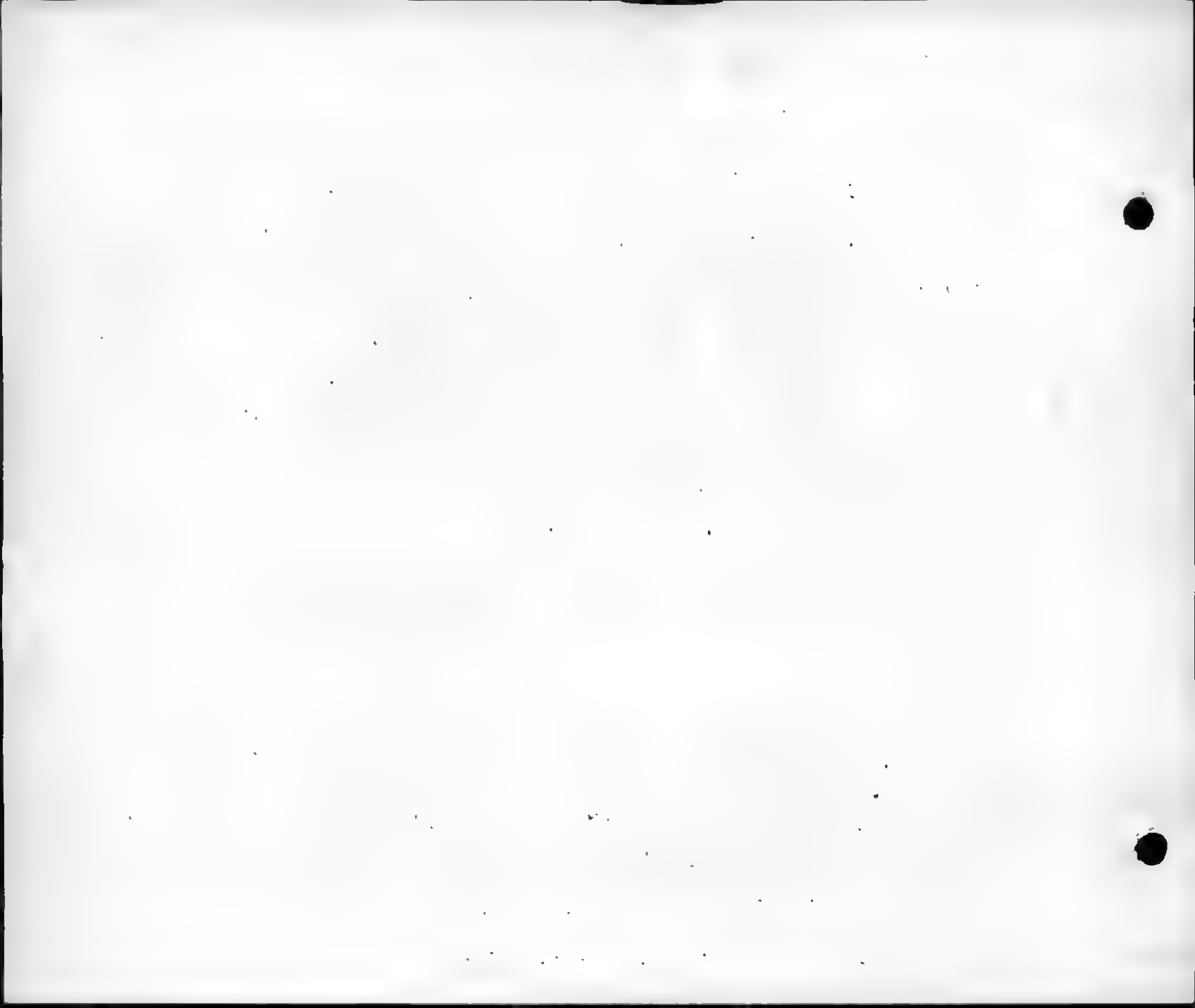
07384  
Reg. Dist. No.

(M)

X

(I)

<b>PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>35 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>840 VIRGINIA AVE.</b>				e. STREET ADDRESS <b>840 VIRGINIA AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>BEATRICE IRENE GRIFFITH</b>				4. DATE OF DEATH <b>JUNE 29 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/1909</b>	
9. AGE (In years last birthday) <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN MILLER</b>			
14. MOTHER'S MAIDEN NAME <b>DAISY STITLEY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>MR. HARRY GRIFFITH</b> <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X carcinoma of the breast</b> DUE TO (b) <b>Ca breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year 5 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>1959</b> to <b>June 1960</b> , that I last saw the deceased alive on <b>June 27, 1960</b> , and that death occurred at <b>745 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D. <b>136 N. Potomac</b>				ADDRESS (Street, city or town, state) <b>6/30/60</b>			
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks</b>				DATE SIGNED			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Korman</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Korman</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7390

CERTIFICATE OF DEATH

07385  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MATYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>10 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1816 GILBERT AVE.</b>				e. STREET ADDRESS <b>/1816 GILBERT AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>FAY</b> Middle <b>WILSON</b> Last <b>GUM</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/ 8/1922</b>		9. AGE (In years last birthday) <b>37</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH GUM</b>				14. MOTHER'S MAIDEN NAME <b>DORA SWICK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If Yes, give branch of service)		16. SOCIAL SECURITY NO <b>216-18-1627</b>		INFORMANT <b>MRS. JESSIE B. GUM</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>3 mo +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 4, 1960</b> to <b>June 18, 1960</b> , that I last saw the deceased alive on <b>June 18, 1960</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>		M.D.		ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b>		DATE SIGNED <b>6/23/60</b>	
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CLDAR LAWN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

1887

# MARYLAND STATE DEPARTMENT OF HEALTH

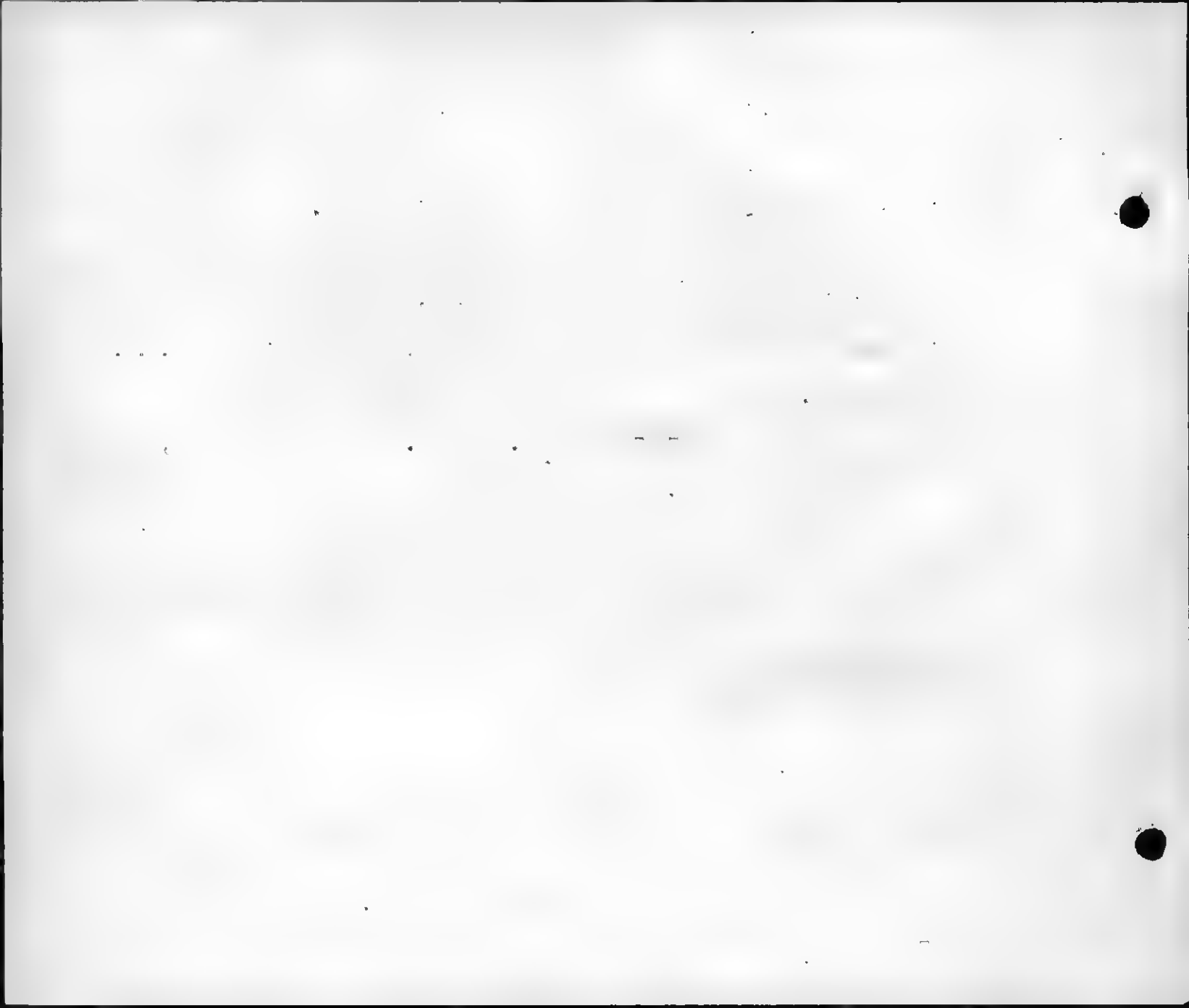
## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 7391 CERTIFICATE OF DEATH

07386

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>107 Linden Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>EDWIN</b> First <b>STEPHEN</b> Middle <b>GUTH</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commissioner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Works Board</b>		11. BIRTHPLACE (State or foreign country) <b>Ironton, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander A. Guth</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-6935</b>		17. INFORMANT <b>Mrs. Sadie C. Guth</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (c) <b>Coronary arteriosclerosis</b> <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>Unknown</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1953</b> to <b>June 25, 1960</b> ; that (I) (we) last saw the deceased alive on <b>June 25, 1960</b> , and that death occurred <b>10:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. L. Packer Jr.</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>6/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. L. Packer Jr. M.D.</b>				22d. ADDRESS <b>145 W. Washington St Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/28/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer</b>				ADDRESS <b>Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 29 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>			

may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07387

7392

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission)			
a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>31 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>C3 Hagerstown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1224 Pinecrest Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY</b> First <b>DELL</b> Middle <b>HARVEY</b> Last				<b>4. DATE OF DEATH</b> <b>June</b> Month <b>15</b> Day <b>1960</b> Year			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 7, 1895</b>		<b>9. AGE</b> (In years last birthday) <b>65</b> yrs	<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Colton, W. Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Wyatt</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Amanda Mc Quain</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>406-38-2156</b>		<b>17. INFORMANT</b> <b>Mr. James C. Hartsaw</b> Address <b>Hagerstown, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> <b>420</b> DUE TO <b>coronary insufficiency &amp; hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 5/18/60 to 6/15/60, 1960, that (I) (we) last saw the deceased alive on 6/15/60, 1960, and that death occurred at 11:35 AM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Howard N. Weeks, M.D.</b>				<b>22b. DATE</b> <b>6/17/60</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Howard N. Weeks, M.D.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>6/18/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>	
<b>23d. LOCATION</b> (City, town, or county) <b>Hagerstown, Maryland</b>				<b>23e. REC'D BY REGISTRAR</b> <b>JUN 20 '60</b>		<b>23f. REGISTRAR'S SIGNATURE</b> <b>William S. Kraus</b>	





7393

## CERTIFICATE OF DEATH

Reg. Dist. No.

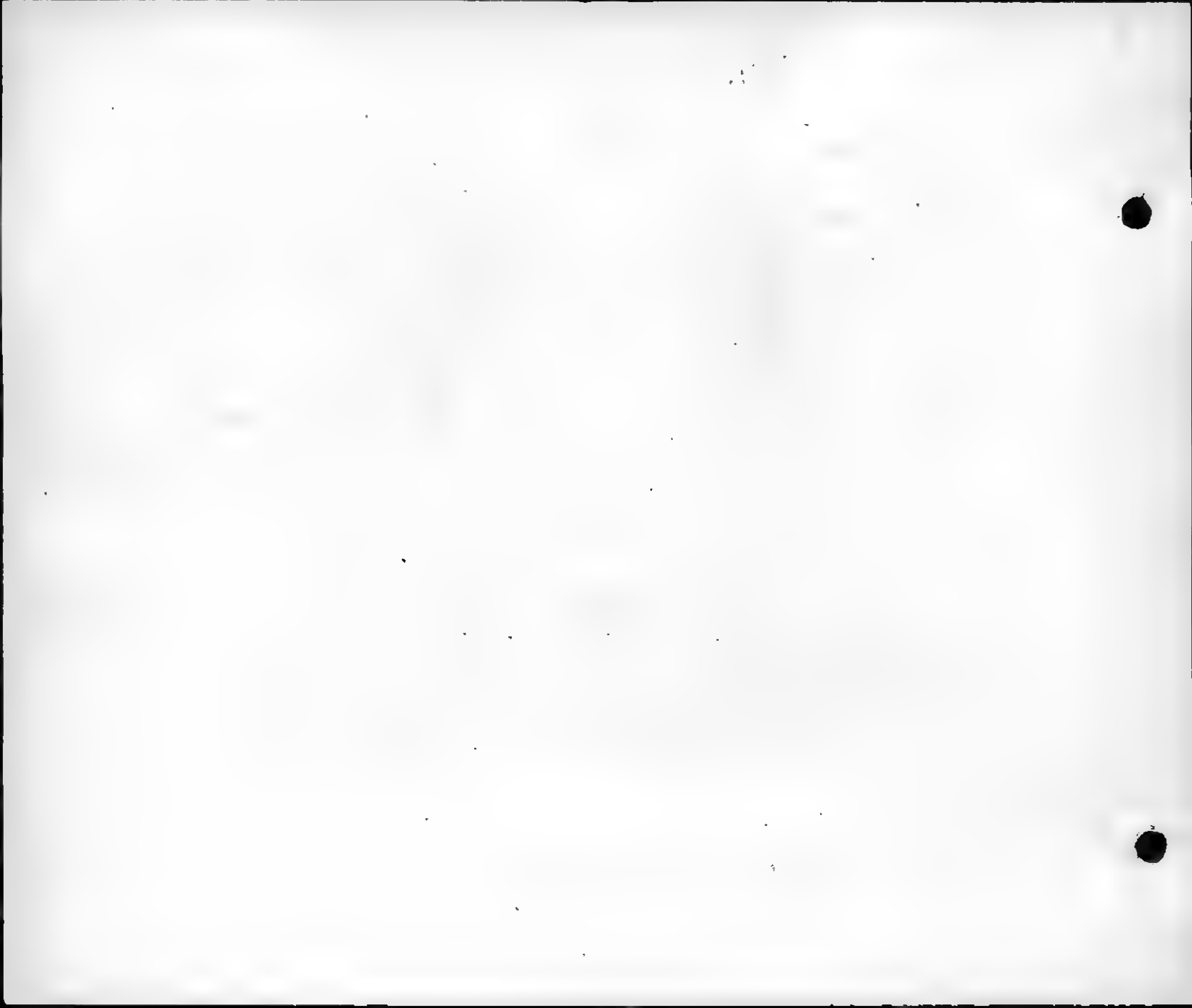
1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET SUE HIGUCHI		4. DATE OF DEATH Month Day Year JUNE 17 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/60
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KIYOSHI HIGUCHI		14. MOTHER'S MAIDEN NAME THELMA TAKEDA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. KIYOSHI HIGUCHI		18. ADDRESS FREDERICK MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 102.5 DUE TO Stalectosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity 2 hrs 40g (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tolemia Noctua (Chronic Hepatitis)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/15/1960, to 6/17/1960, that I last saw the deceased alive on 6/17/1960, and that death occurred at 11:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. Bacon		ADDRESS (Street, city or town, state) 101 King St Hagerstown Md	
PHYSICIAN'S NAME (Type) A. M. Bacon M.D.		DATE SIGNED	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) CREMATION	22b. DATE THEREOF 6/18/60	22c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CREM.	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment Hagerstown Md		24a. REC'D BY REGISTRAR DATE JUN 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

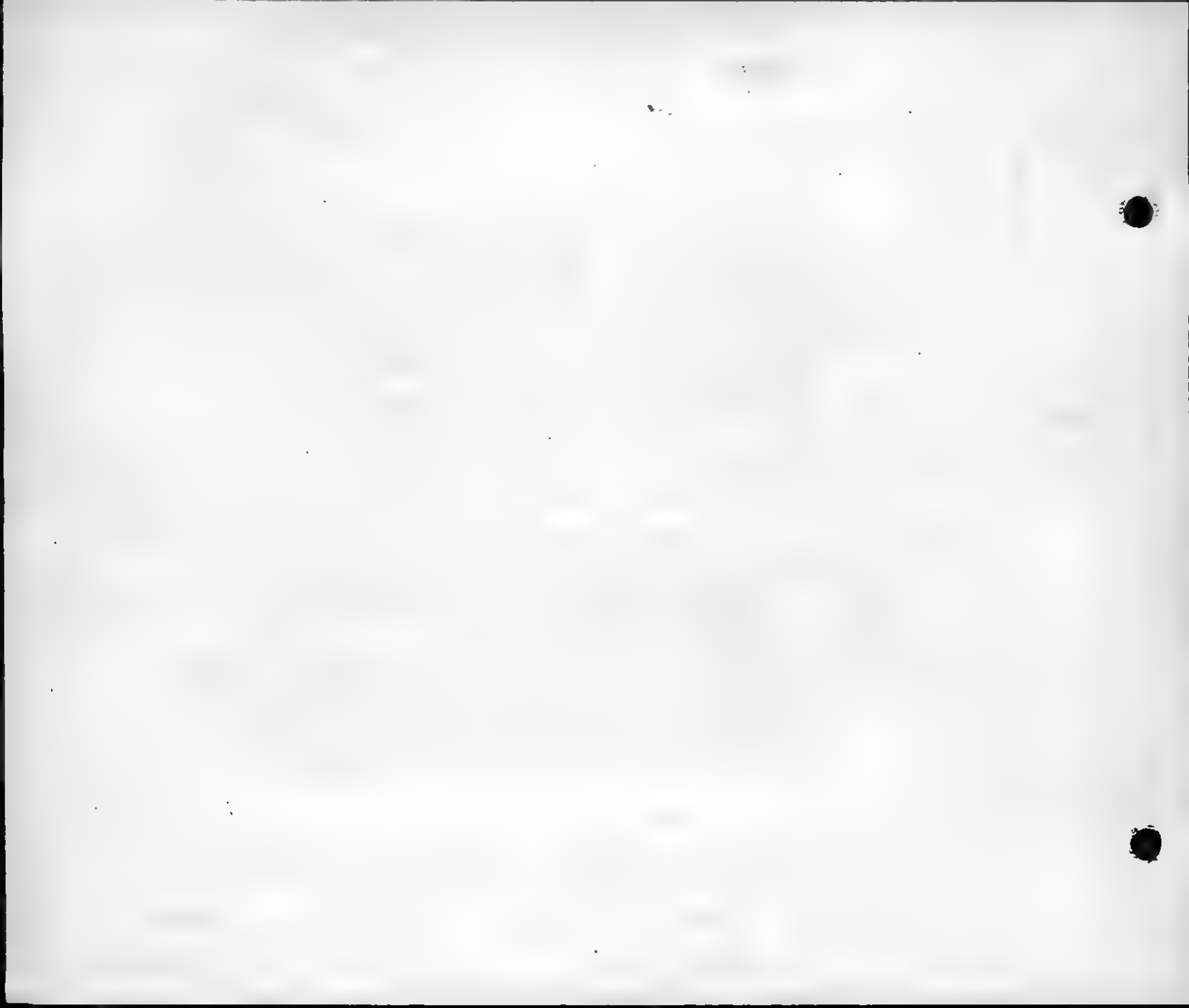
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>18 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 EAST FIRST STREET</b>		d. STREET ADDRESS <b>124 EAST FIRST STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALVA LUTHER HUTZEL</b>		4. DATE DEATH Month Day Year <b>JUNE - 18 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT-4-1881</b>	9. AGE (in years last birthday) <b>78</b> yrs	IF UNDER 1 YEAR Months Days Hours Min. <b>9 14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATION FURNITURE MFG. CO. FRED. CO. MD.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL E. HUTZEL</b>		14. MOTHER'S MAIDEN NAME <b>EMMA McBRIDE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-5874</b>		17. INFORMANT <b>AUSTIN W. HUTZEL</b> Address <b>825 S. POTOMAC ST. HAGERSTOWN MD. 21</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> 4:00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH minutes <b>36 hours.</b> <b>Indefinite.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>Hour 2 p.m.</b>		20d. INJURY OCCURRED <b>While at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at work</b>	
20f. (City or town) <b>Hagerstown</b>		20g. (County) <b>Washington</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>February 1959</b> death, 19, that (I) (we) last saw the deceased alive on <b>June 16, 1960</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above					
22a. SIGNATURE <b>Robert F. Keadle</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 18, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>		22d. ADDRESS <b>Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE-20-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>HAGERSTOWN WASH. CO. MD.</b>		23e. (State) <b>MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Burt</b>		ADDRESS <b>BOONSBORO WASH. CO. MD.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07390

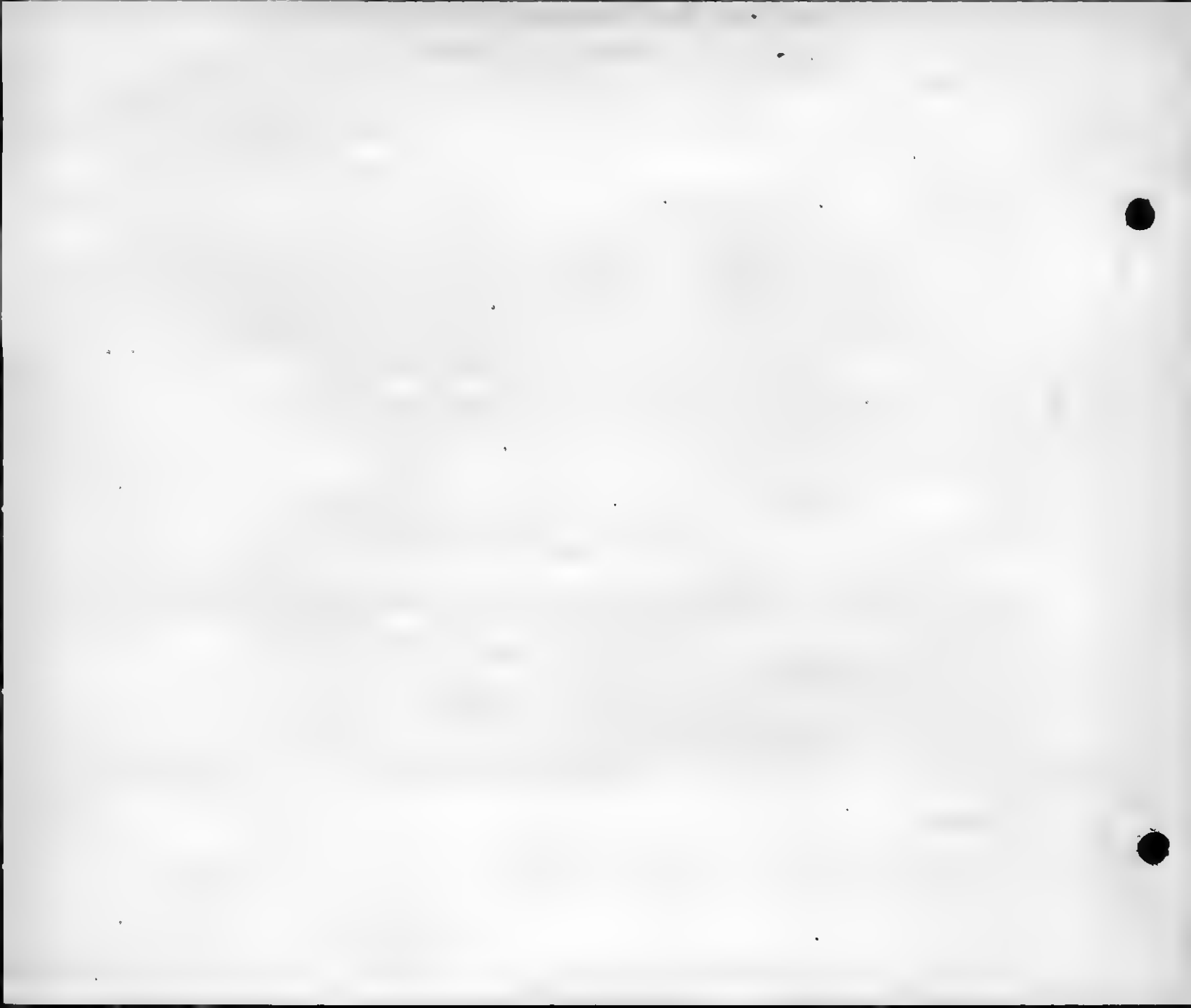
Reg. Dist. No.

7442

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before adm ss'n) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Boonesboro		c. LENGTH OF STAY IN 1b 15 1/2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boonesboro Md. #2 Keedy Fahrney Memorial Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg	
3 NAME OF DECEASED (Type or print) First Middle Last Edward Harris Ingram		4. DATE OF DEATH Month Day Year June 26, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1864
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchard owner		10b. KIND OF BUSINESS OR INDUSTRY Luenenburg, Nova Scotia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Silas W. Ingram		14 MOTHER'S MAIDEN NAME Melissa Smith	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Ray F. Ingram Smithsburg Md., #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.3 Chronic generalized arteriosclerosis DUE TO (b) Carcinoma of left side of face DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 yr 6 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1960, to June 26, 1960, that I last saw the deceased alive on June 25, 1960, and that death occurred at 5:14 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Hecker		ADDRESS (Street, City or town, state) Boonesboro Md. DATE SIGNED 6/25/60	
PHYSICIAN'S NAME (Type) G. W. Hecker			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60	
22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or county) Plainfield (State) N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Z. Shaw, Hagerstown, Pa		24a. REC'D BY REGISTRAR DATE JUN 29 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

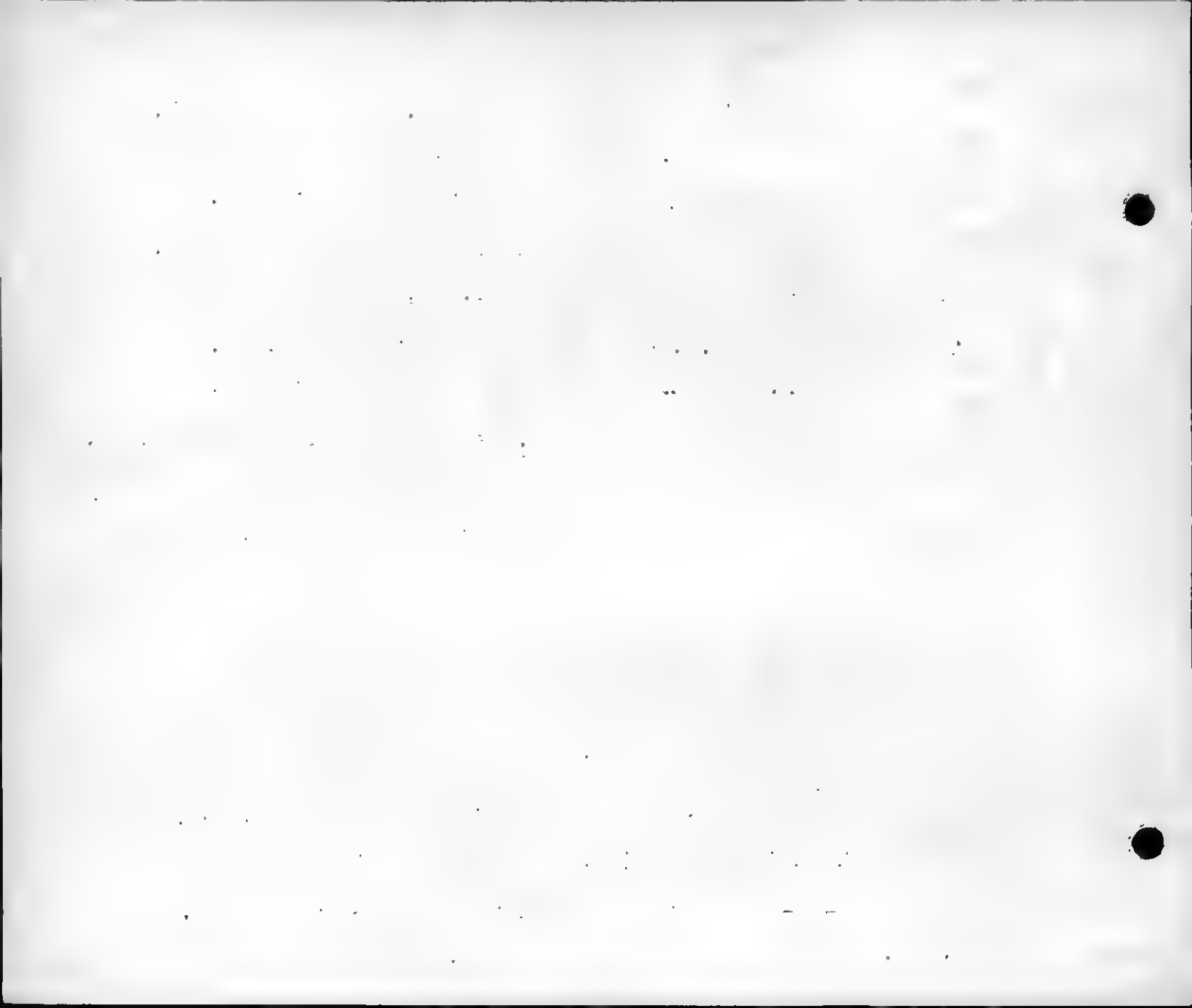
7395

## CERTIFICATE OF DEATH

07391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1600 Jefferson Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mildred</b> First <b>Elsie</b> Middle <b>Itneyer</b> Last		4. DATE OF DEATH <b>June 7,</b> Month <b>1960</b> Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mail sorter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>near Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Clyde B. Itneyer</b>		14. MOTHER'S MAIDEN NAME <b>Lulu Neff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Nellie Lytton, Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> DUE TO (b) <b>Carcinoma of the uterus, original site</b> DUE TO (c) <b>lying cause lost.</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>17 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan.</b> , 1959, to <b>June 7</b> , 1960, that I last saw the deceased alive on <b>June 7</b> , 1960, and that death occurred at <b>5:40 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Md.</b> DATE SIGNED <b>6/8/60</b>	
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>6-10-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>





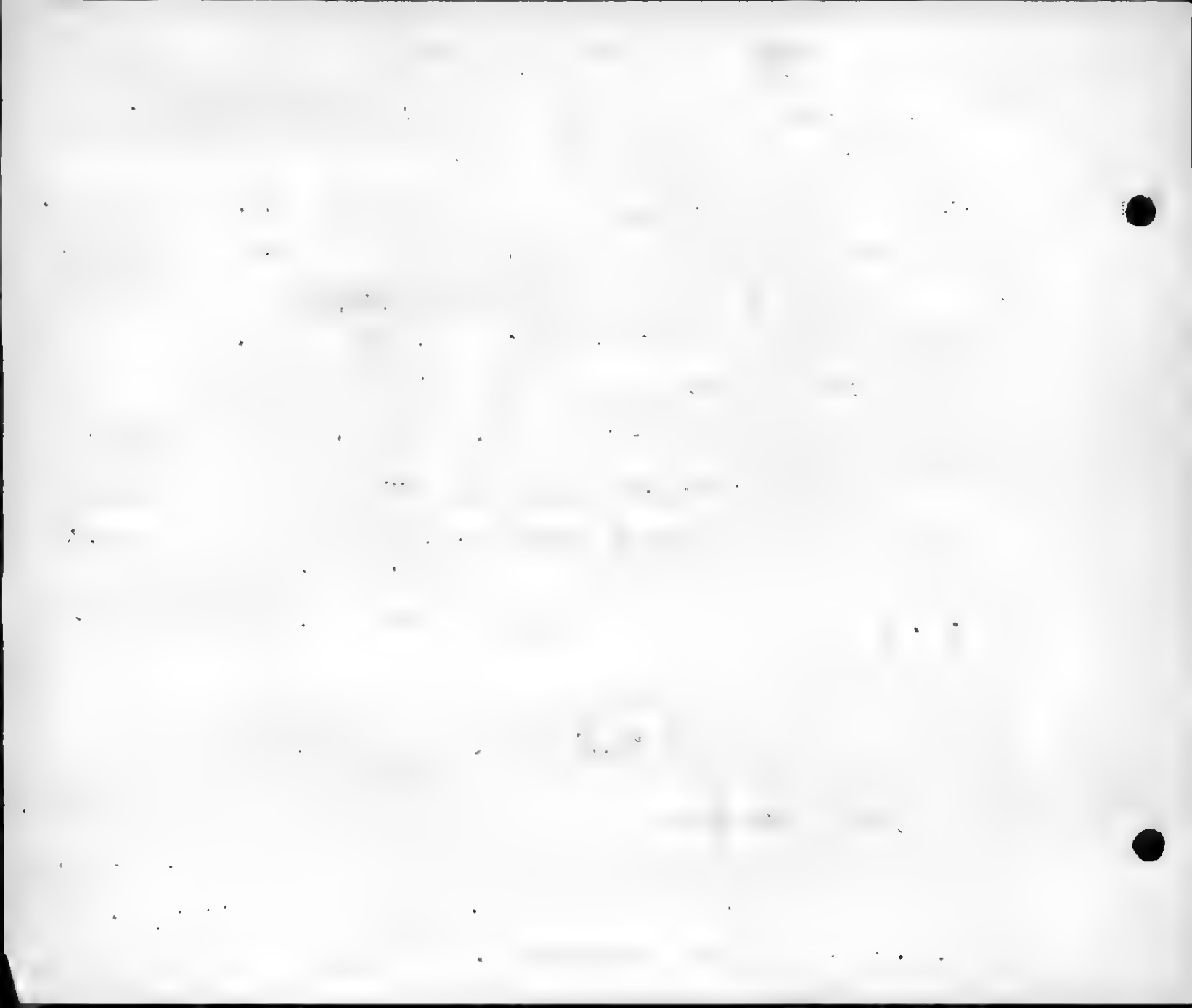
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>33 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Henry Johnson</b>				4. DATE OF DEATH Month Day Year <b>6 23 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>1872 March 12 1882</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>gardener</b>		11. BIRTHPLACE (State or foreign country) <b>Falling Waters W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Charles H. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Tobiasse Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>213-42-1359</b>		17. INFORMANT Address <b>Reginald Johnson 125 W Church Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1216X address</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>no phoschisms &amp; genit antenosclicose</b> DUE TO (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/4/60</b> , 19___, to <b>6/23/60</b> , 19___, that I last saw the deceased alive on <b>6/23/60</b> , 19___, and that death occurred at <b>6:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>136 N. Potomac St., Hagerstown, Md. 6/25/60</b>							
ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D. Hagerstown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-27-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John R Watson Jr. Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







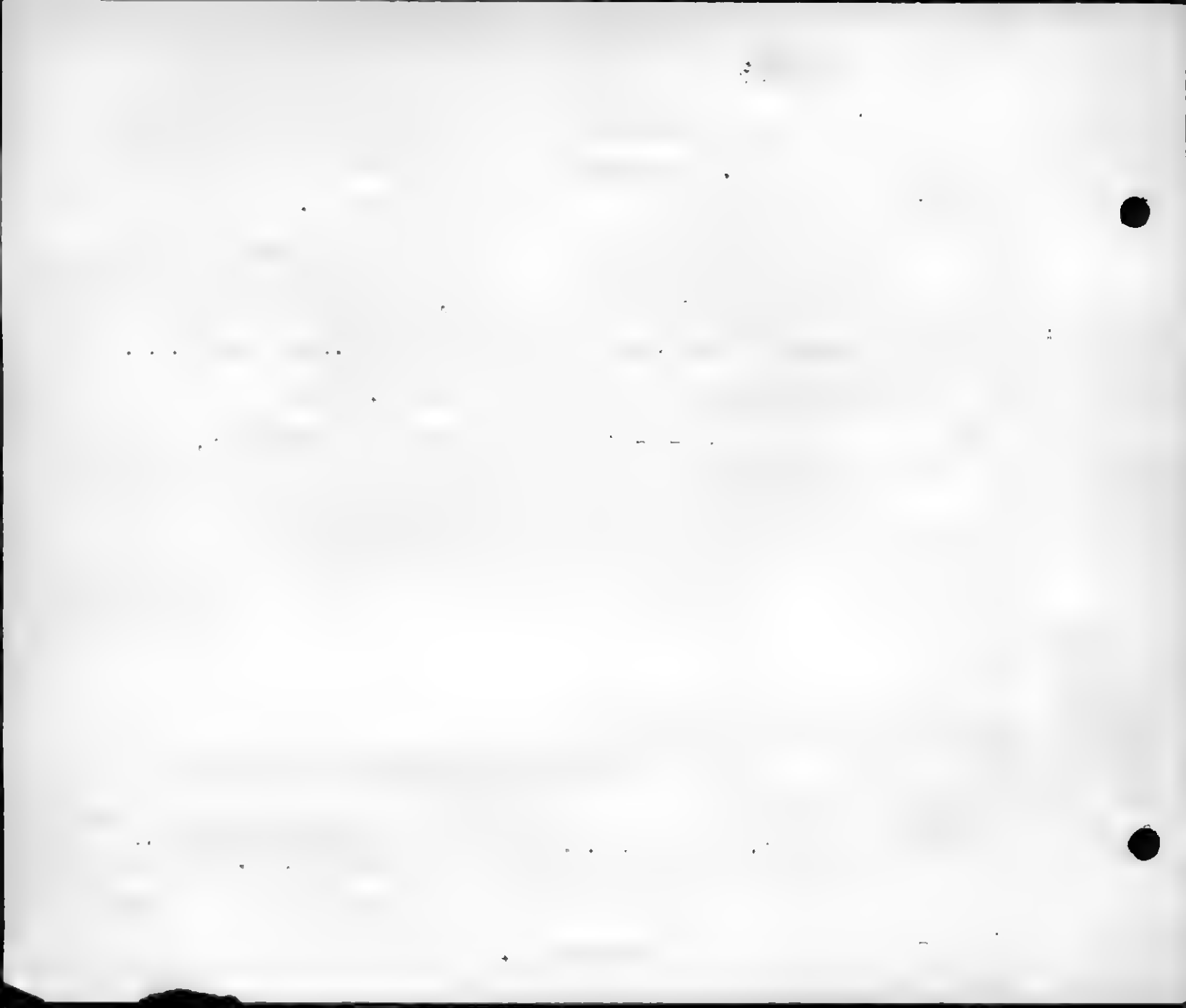
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07394

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>55 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
		d. STREET ADDRESS <b>1859 Virginia Ave.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RICHARD</b> First <b>DAVIS</b> Middle <b>KERFOOT</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Yard Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Jacob Kerfoot</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Arthur</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO <b>705-10-5023</b>	
17. INFORMANT <b>Robert Kerfoot</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Death by ventricular failure</b> <b>4-4-3*</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive - arteriosclerotic Heart Disease</b> DUE TO (c) <b>Unknown many years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>11-1-1950</b> to <b>6/28-1960</b> that (I) (we) last saw the deceased alive on <b>6/28-1960</b> and that death occurred at <b>3:15 PM</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker</b>		22b. DATE SIGNED <b>6:29:60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/1/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Houzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. DR. RALPH YOUNG

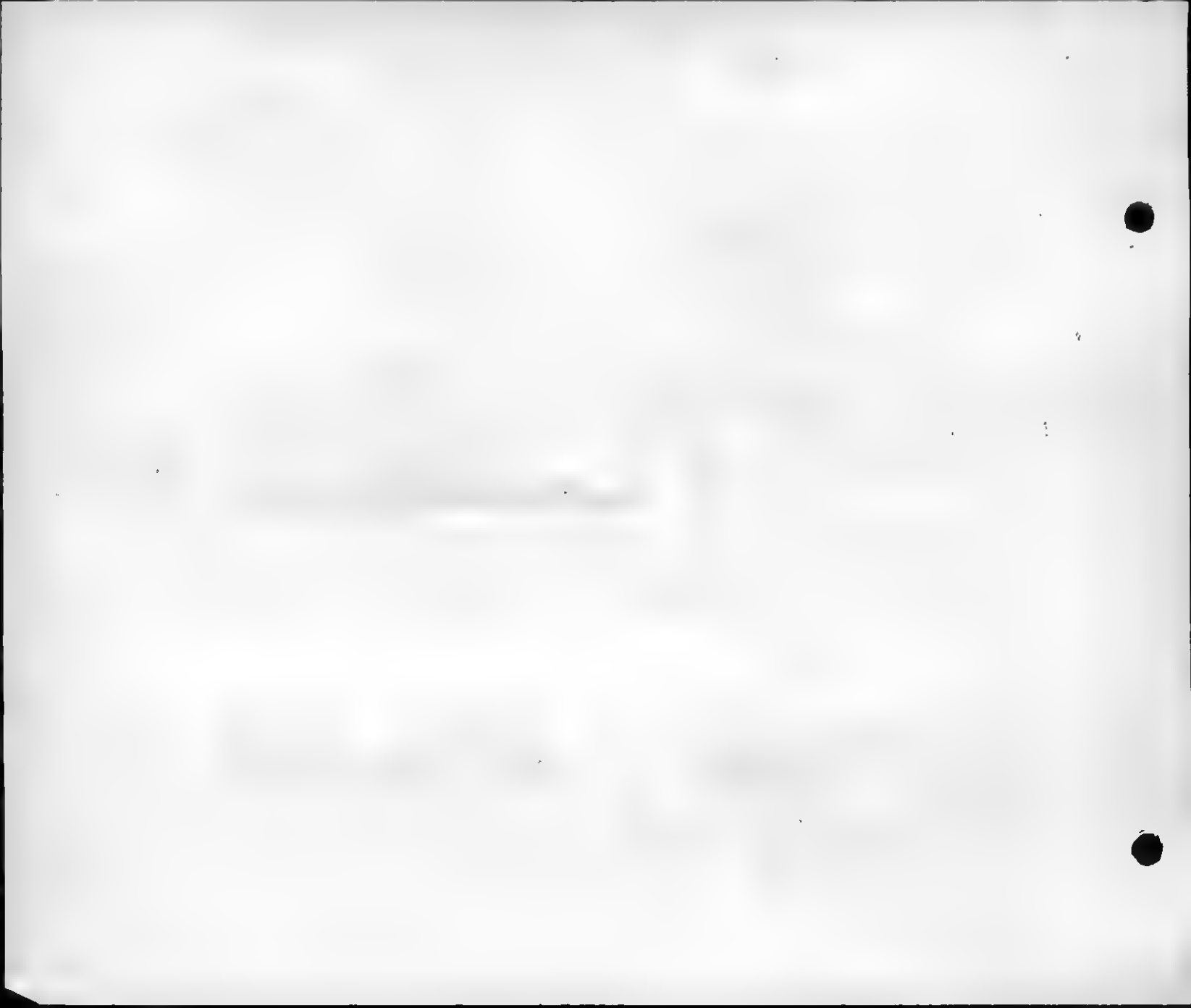
WILLIAMSBORO MD

7399

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07396

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>40 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>838 FREDERICK ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTIE LARUE LANTZ</b>				4. DATE OF DEATH Month Day Year <b>JUNE - 8 - 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 3, 1874</b>	9. AGE (In years lost birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min <b>5 5</b>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>HANOVER PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM YANTIS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET YANTIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>FRANK TANGER</b> Address <b>838 FREDERICK ST. HAGERSTOWN MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Immediate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Immediate</b> (c) DUE TO <b>Immediate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/7/60</b> to <b>6/8/60</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6/8/60</b> , 19 <b>60</b> , and that death occurred on <b>6/8/60</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Ralph Young</b>				22b. ADDRESS <b>Boonsboro MD.</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 11, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John D. East</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	





7432

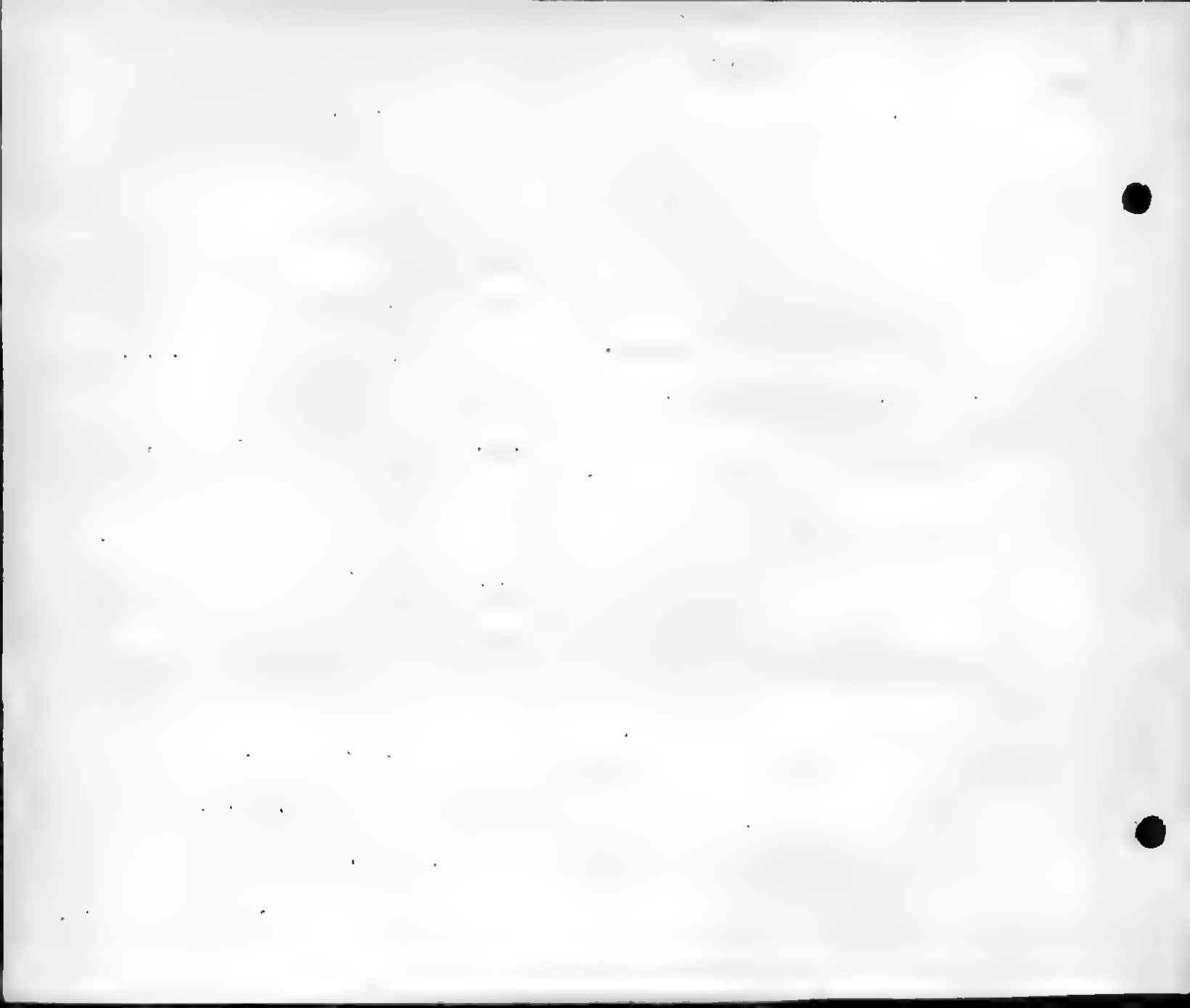
## Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if deceased lived here) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Saniatarium</b>		e. STREET ADDRESS <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) <b>Jacob</b> First <b>Henry</b> Middle <b>Lingamfelter</b> Last <b>Lingamfelter</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 5, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>	11. IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>Jacob Charles Lingamfelter</b>		14. MOTHER'S MAIDEN NAME <b>Annabell Small</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Mrs. W. Hoge Light, Martinsburg, Rt 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO <b>5 yrs</b> (c) <b>(First stroke July 10, 1957-)</b> DUE TO <b>3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Interstitial Nephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1957</b> to <b>June 28, 1960</b> , that I last saw the deceased alive on <b>June 28, 1960</b> , and that death occurred at <b>5:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6-28-60 DATE SIGNED</b> ACTUAL SIGNATURE <b>Victor L. Glover</b> M.D. <b>407 W. King St. Martinsburg, W. Va.</b> PHYSICIAN'S NAME (Type) <b>VICTOR L. GLOVER, M.D.</b> <b>MARTINSBURG</b> <b>W. Va.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 1, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Alexander Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>West Alexander, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kline</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

**TO HOSPITAL:** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
LSM 9/58



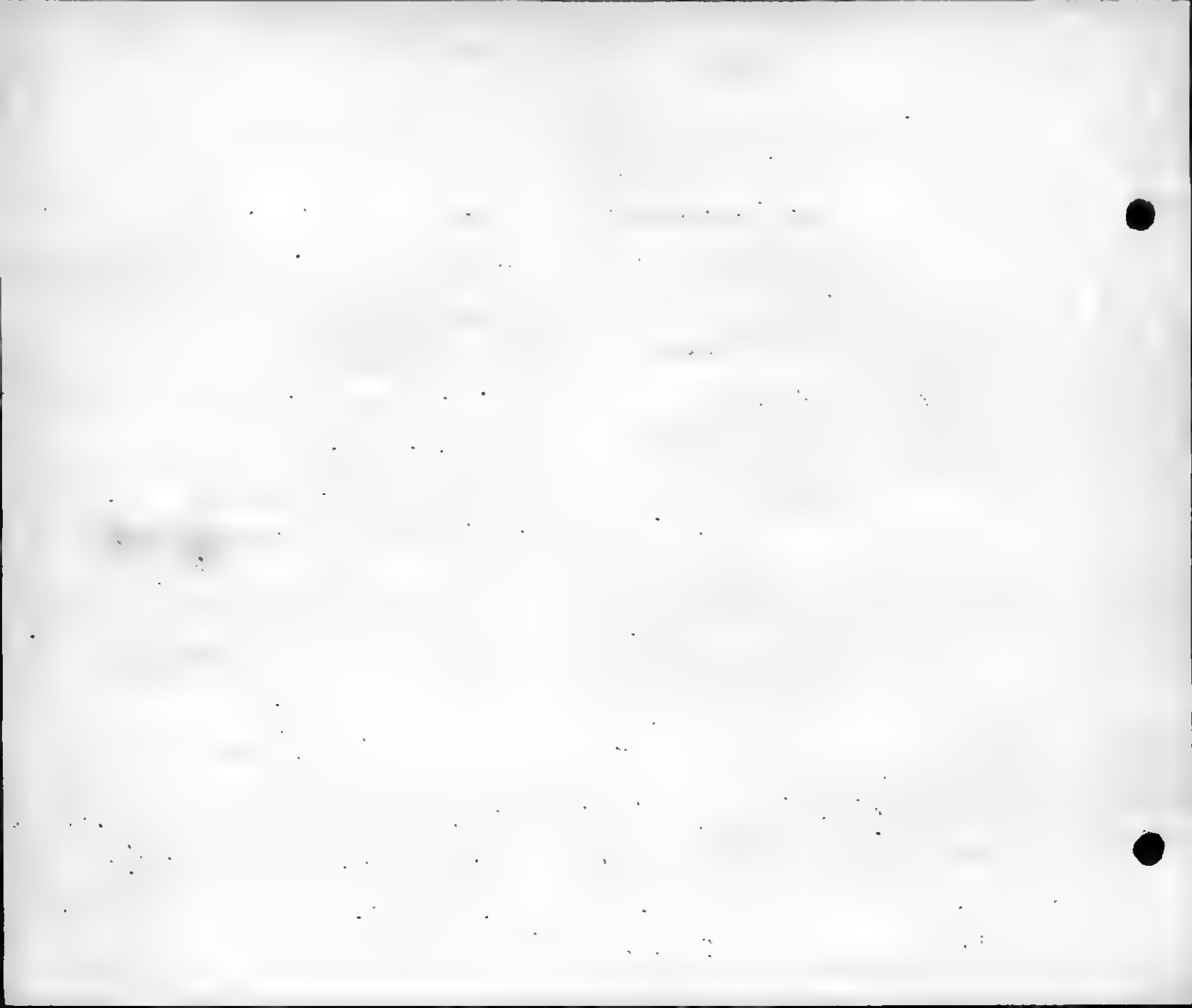
7433  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN TB <u>5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>114 West Potomac St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Wesley</u> Last <u>Lizer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	11. IF UNDER 24 HRS Hours <u>20</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boatsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canal</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Lizer</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> DUE TO <u>Diffuse Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
19a. TIME OF INJURY Month <u>Aug</u> Day <u>1</u> Year <u>1958</u> Hour <u>a. m.</u> p. m. <u>19</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		19d. (City or town) (County) (State) <u>Williamsport</u> <u>Md.</u>	
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>June 2, 1960</u> , that I last saw the deceased alive on <u>June 2, 1960</u> and that death occurred at <u>12:30</u> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>M E Byrkit</u> M.D.		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>6-3-60</u>	
PHYSICIAN'S NAME (Type) <u>M E Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u> ADDRESS <u>Williamsport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



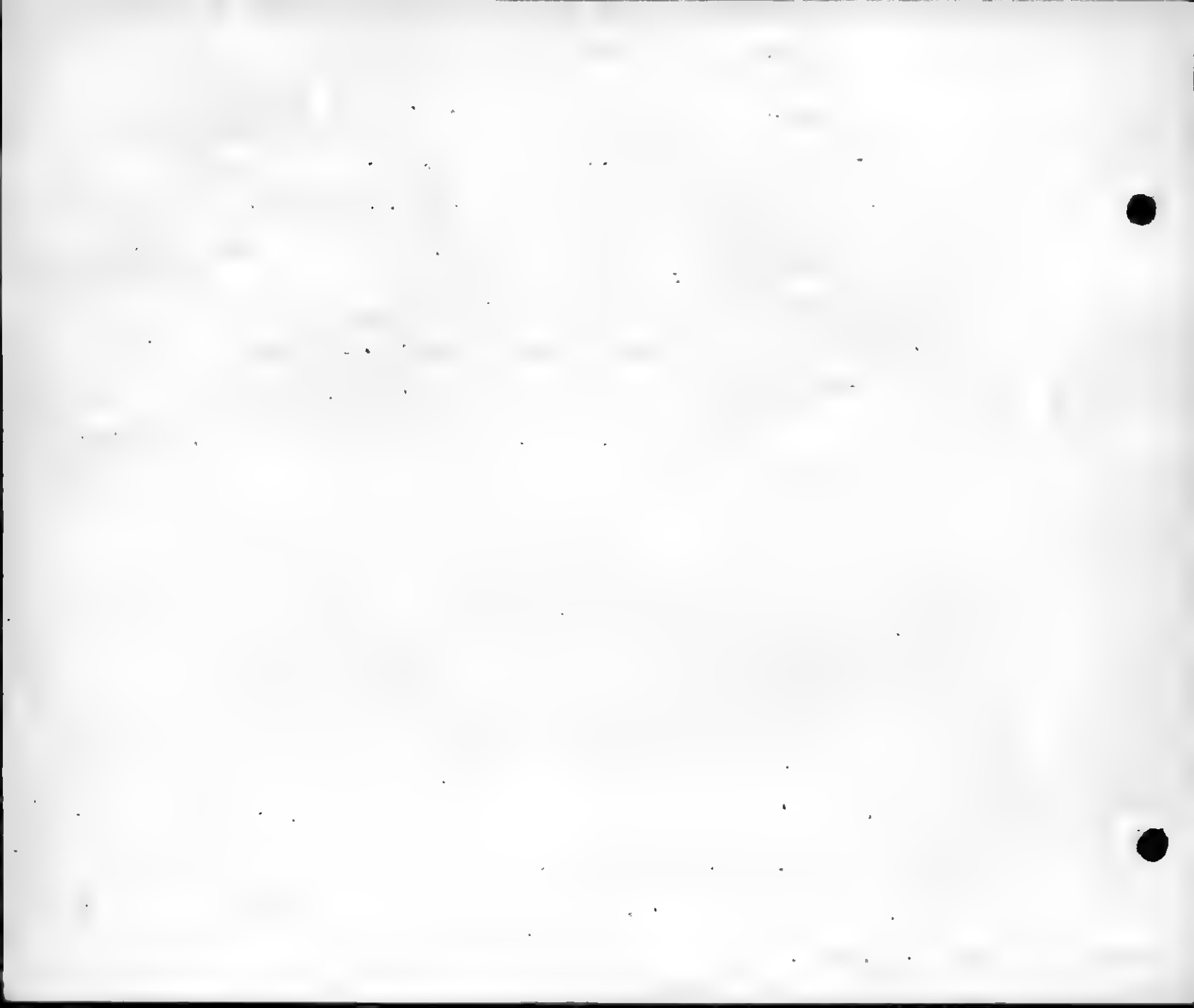
# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) o. STATE		Maryland		If institution: Residence before admission) b. COUNTY		Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN TB				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Hagerstown				17 yrs.				Hagerstown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				Washington County Hospital				d. STREET ADDRESS				333 S. Mulberry St.			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
ELLIS		PORTER		LYNCH				June		27		19		60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 20, 1896		63 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Engineer				Fairchild Aircraft				Fulton County, Penna.				USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
Biddis Lynch						Della Gordon									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				INFORMANT				Address			
No				217-18-2765				Mrs. E. P. Lynch				333 S. Mulberry St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary Embolism</u> DUE TO <u>254X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general arteriosclerosis and cerebral</u> DUE TO <u>2-4 yrs</u> (c) <u>arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pancreatitis</u> <u>Hered. gastric ulcer</u> <u>Prostate hypertrophy</u>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1</u> , 1959, to <u>June 27</u> , 1960, that I last saw the deceased alive on <u>June 27</u> , 1960, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 West Washington Street</u> DATE SIGNED <u>6/28/60</u> ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. <u>Hagerstown, Maryland</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u> <u>Hagerstown, Maryland</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
Burial				6/29/60				Rest Haven Cemetery				Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Rest Haven Funeral Chapel						Hagerstown, Md.						DATE JUN 30 '60		Arthur S. Kraus	

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

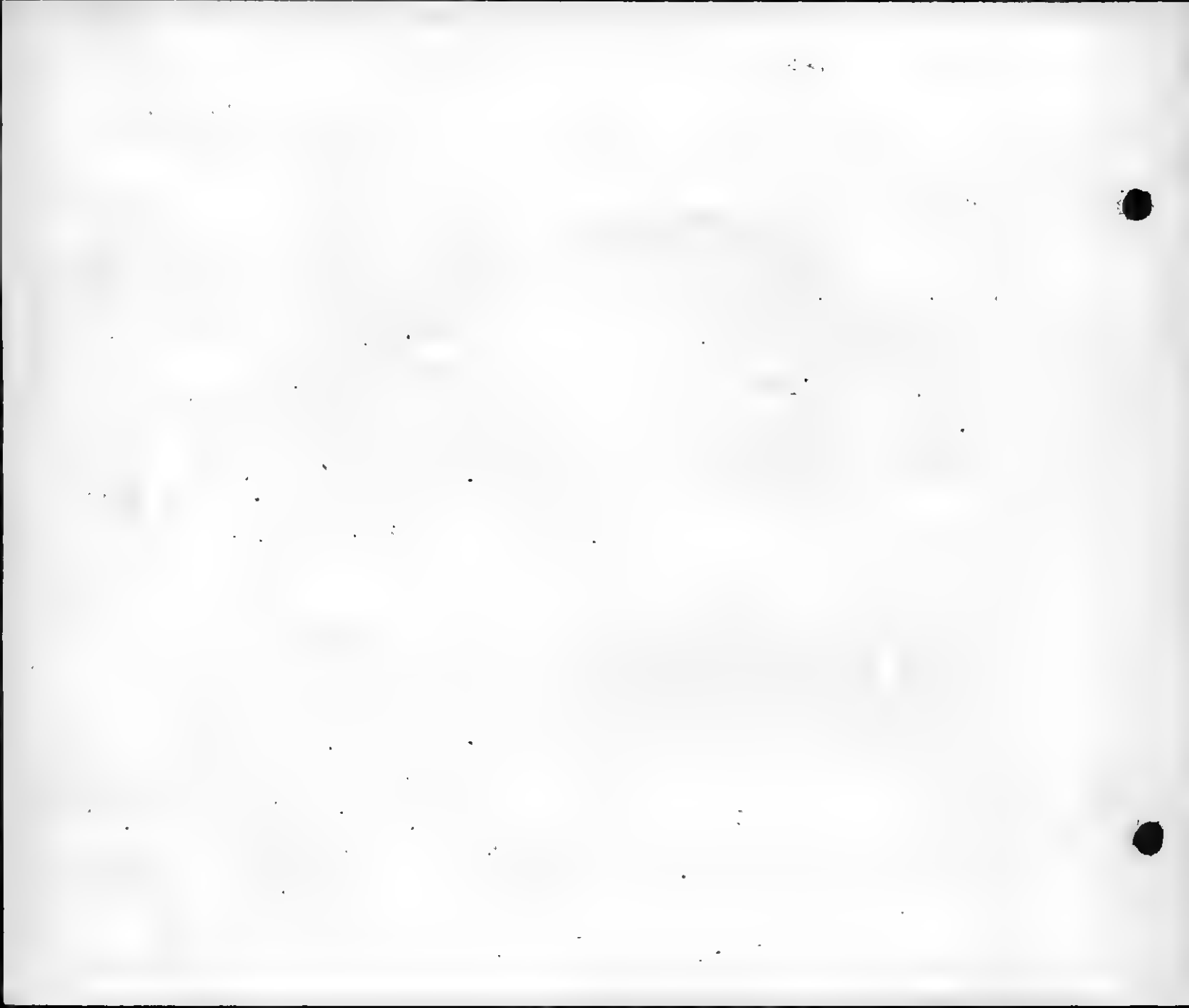
7401

CERTIFICATE OF DEATH

07400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>6 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>321 S. CANNON AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>321 S. CANNON AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>PRUDENCE</b> Middle <b>MAGAHA</b> Last 4. DATE OF DEATH <b>JUNE</b> Month <b>23</b> Day <b>19</b> Year <b>60</b>							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/4/1880</b>	
9. AGE (In years lost birthday) <b>80</b> Yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THOMAS BRASHEARS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH PETERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MISS EVA CHURCHEY</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>cardiovascular collapse</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic</b> DUE TO <b>gen</b> (c) <b>arteriosclerotic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 1/2 hrs.</b>							
19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6/15</b> , 19 <b>60</b> to <b>6/23</b> , 19 <b>60</b> and that death occurred at <b>6:08</b> M, from the causes and on the date stated above. alive on <b>6/22</b> , 19 <b>60</b> , and that death occurred at <b>6:08</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 E. Antietam Hagerstown, Md.</b> DATE SIGNED <b>6/24/60</b>							
ACTUAL SIGNATURE <b>L. J. Murphy</b> M.D.				PHYSICIAN'S NAME (Type) <b>HOWIE G. GROSS M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>FERDERICK MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





7443

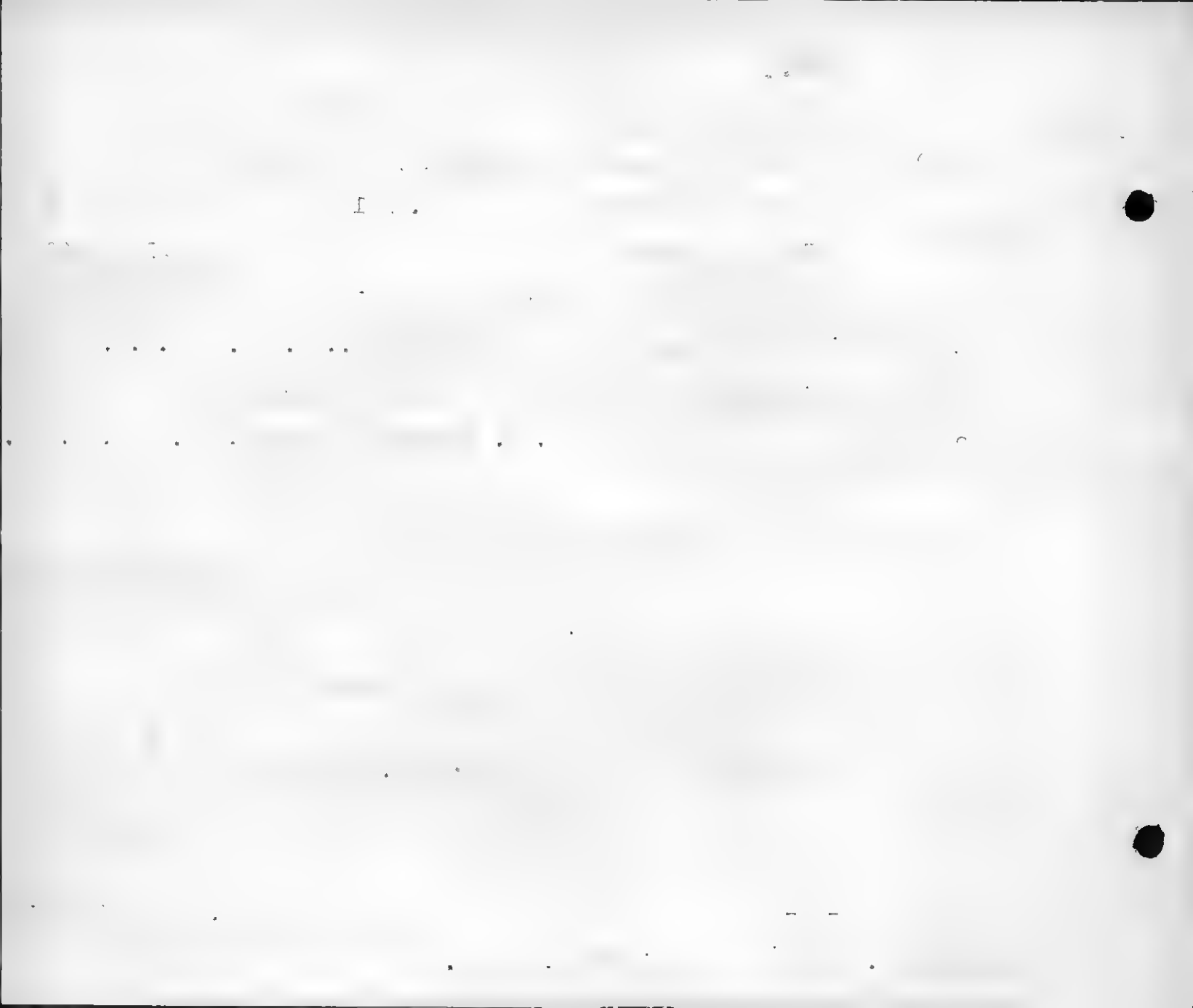
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07401

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>WEST VIRGINIA</b> COUNTY <b>BERKELEY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) INWOOD</b>	
c. LENGTH OF STAY IN 1b <b>5 months</b>		d. STREET ADDRESS <b>Rt. # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GATEWAY NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MAE</b> Last <b>MASTERS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkeley Co., W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph Parkinson</b>		14. MOTHER'S MAIDEN NAME <b>Emily Katherine Shade</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>J. D. Masters</b>		Address <b>Inwood, Rt. # 1, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic Endocarditis</b> DUE TO Candidiasis, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>724 X</b> (b) <b>Articular Rheumatism</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Pulmonary Tuberculosis - arrested</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1958</b> to <b>June 21, 1960</b> that (I) (we) last saw the deceased alive on <b>June 21, 1960</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Glover, M.D.</b>		22b. DATE SIGNED <b>June 23, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. GLOVER, M.D.</b>		22d. ADDRESS <b>404 WEST KING ST MARTINSBURG, W. VA.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-23-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Martinsburg, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>		25a. REC'D BY REGISTRAR <b>JUN 27 '60</b>	
ADDRESS <b>Martinsburg, W. Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

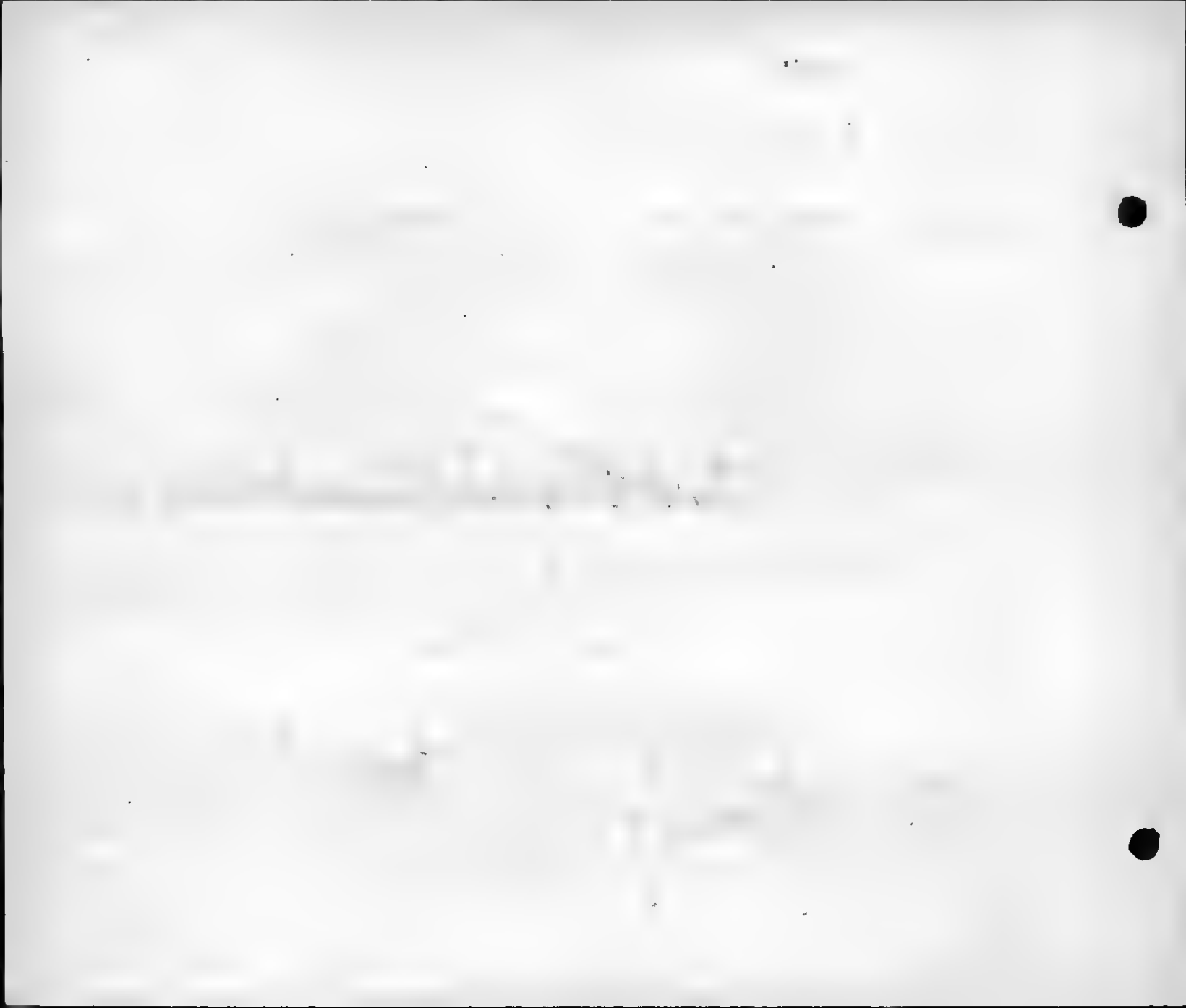
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07402

7402

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>12 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRETHERSVILLE 'RURAL'</u> d. STREET ADDRESS <u>1 BOONSBORO MD. R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ALVEY LEE MAYHUGH</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE - 24 - 1960</u>			
<b>5 SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY-2-1896</u>	
<b>9. AGE</b> (In years last birthday) <u>64 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <u>1 22</u>		<b>IF UNDER 24 HRS</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED MACHINIST</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>VICTOR PRODUCTS CORP.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>HARRY MAYHUGH</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>AMANDA HOOVER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>220-18-1026</u>		<b>17. INFORMANT</b> <u>MRS. EDNA MAYHUGH</u> Address <u>BOONSBORO MD. R.I.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO <u>Thrombotic Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. Month Day Year <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> _____ (County) _____ (State) _____				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/13/60</u> <b>to</b> <u>6/24/60</u> <b>that (I) (we) last saw the deceased alive on</b> <u>6/13/60</u> <b>and that death occurred at</b> <u>7 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Ralph F. Young</u>				<b>22b. DATE SIGNED</b> <u>6/24/60</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RALPH F. YOUNG</u>	
<b>22d. ADDRESS</b> <u>WILLIAMSPORT MD.</u>				<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>JUNE 27, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>REST HAVEN CEMETERY</u>		<b>23d. LOCATION (City, town, or county)</b> <u>HAGERSTOWN WASH. CO. MD.</u> (State) _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John A. Rad.</u> Address <u>BOONSBORO MD</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUN 28 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knecht</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be filed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

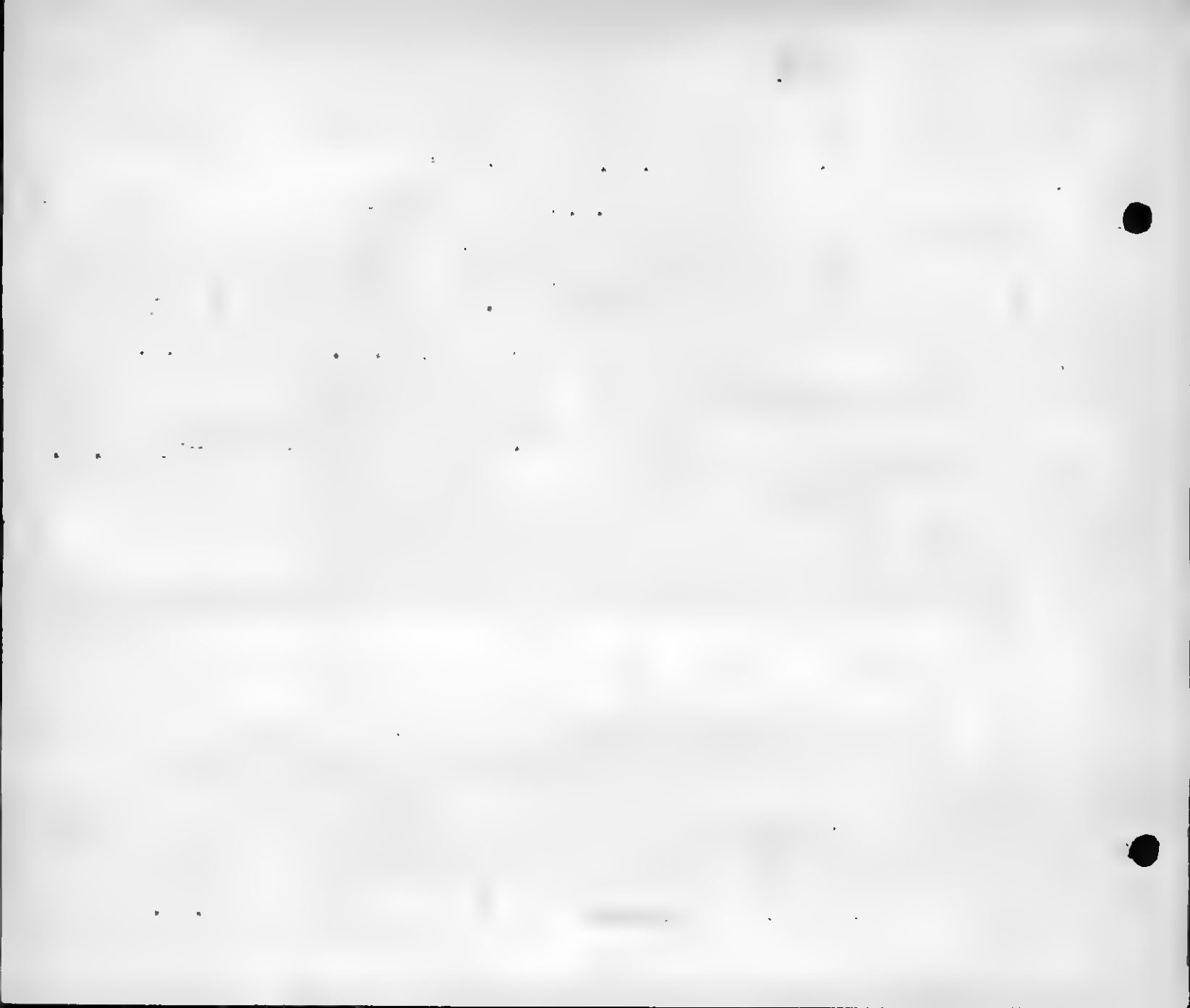
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07403

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Gloucester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>D. O. A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital D.O.A</b>		e. STREET ADDRESS <b>803 Broadway</b>	
3. NAME OF DECEASED (Type or print) <b>Douglas Gary Merriell</b>		DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>Feb. 27 1960</b>	9. AGE (in years last birthday) <b>3</b> yrs <b>11</b> months <b>11</b> days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodbury N. J.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wallace Merriell</b>		14. MOTHER'S MAIDEN NAME <b>Joan Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mr. Wallace Merriell</b>		Address <b>803 Broadway Westville N. J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>924.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 min</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Placed in crib - face down - face became entangled in plastic bag at bottom of carriage</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:15 p.m. 6 6 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>Home</b>	20f. (City or town) (County) (State) <b>W. Williamsport Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Dittus</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward W. Dittus, Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eglinton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksboro N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		DATE SIGNED <b>6/6/60</b>	

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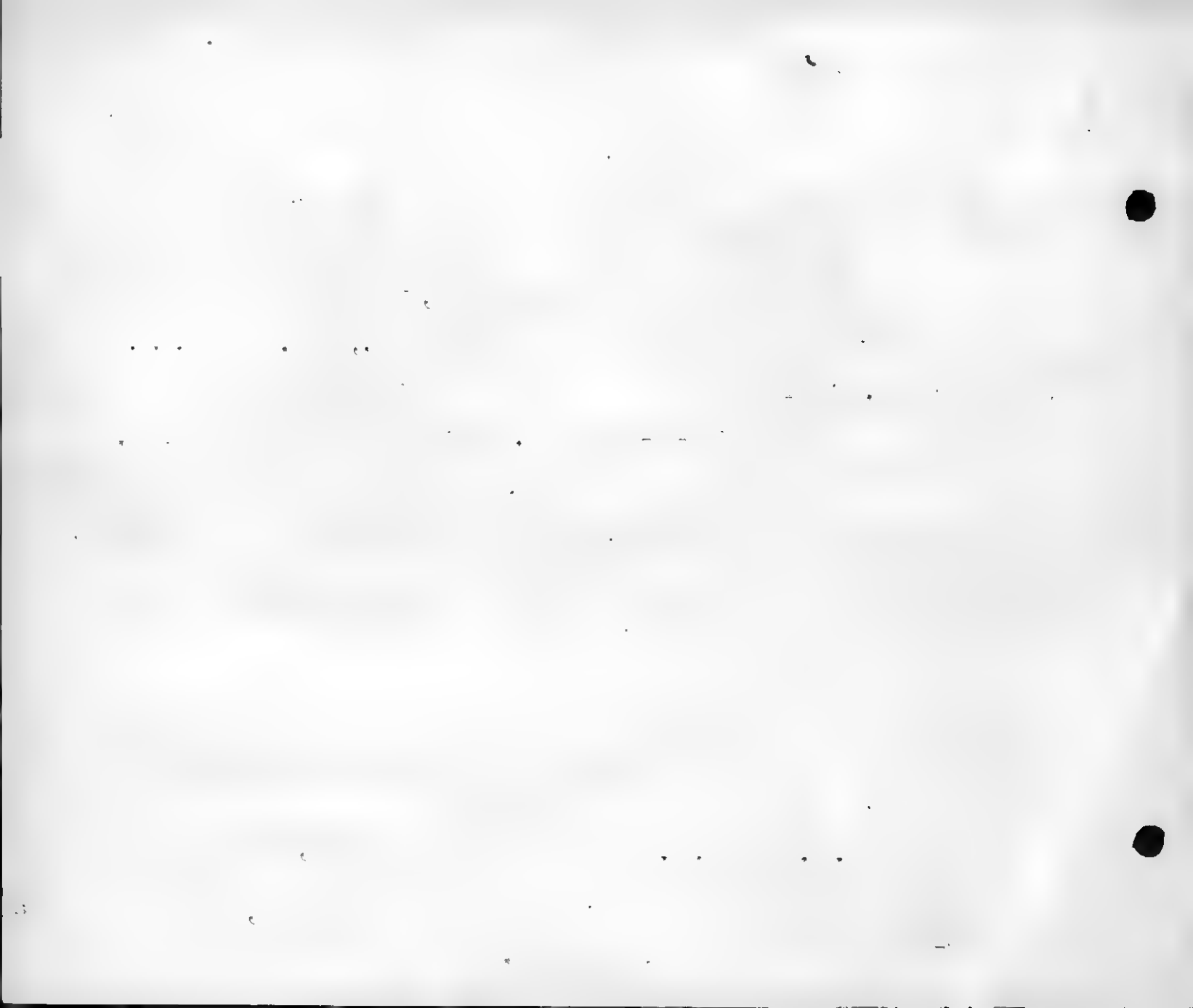


1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07404

7404

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>22 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>413 George Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CHALICE</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1895</b>
9. AGE (In years lost birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooks Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restraunt</b>	
11. BIRTHPLACE (State or foreign country) <b>Franklin Co., Penn. 1/2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Linnie Holsinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>188-09-5447H</b>	
17. INFORMANT <b>Mrs. Virgie Daley</b>		Address <b>Shady Grove, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4-20-0</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure due to</b> DUE TO <b>Arteriosclerotic Heart Disease.</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Years.</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Bronchial Asthma and Emphysema.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1960</b> to <b>June 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>6-26-1960</b> , and that death occurred at <b>8PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. A. Bell</b>		22b. DATE SIGNED <b>June 28, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>		22d. ADDRESS <b>Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/29/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Waynesboro, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 29 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07405

7405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>ONONDAGA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYRACUSE</b>		d. STREET ADDRESS <b>532 NORTH SALINA STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANTOINETTE</b> Middle <b>NASTRI</b> Last				4. DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 16 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILORING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SUIT MANUFACTORS</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>? DIMASI</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>EDMUND NASTRI 244 HARDING ST SYRACUSE N.Y.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute subarachnoid and</b> <b>325X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subarachnoid Hemorrhage</b> DUE TO (c) <b>446</b>							INTERVAL BETWEEN ONSET AND DEATH <b>about</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>multiple body contusions multiple fractured ribs</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was thrown from auto in accident</b>					
20c. TIME OF INJURY Month, Day, Year <b>6 14 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Mr. Frederick, Fred. Rd</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/17/60</b>	
EXAMINER'S NAME (Type) <b>E W DITTO III</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ASSUMPTION CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SYRACUSE NEW YORK</b>	
23. SUPERIOR FUNERAL HOME <b>Charles M. KOUZER</b>				ADDRESS <b>HAGERSTOWN MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hume</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07406

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAPLAND RURAL</u> c. LENGTH OF STAY IN 1b <u>38 YEARS</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GAPLAND RURAL</u> d. STREET ADDRESS <u>1 GAPLAND MD.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLARENCE EDWARD NORRIS</u>				<b>4. DATE OF DEATH</b> Month <u>JUNE</u> - Day <u>20</u> - Year <u>1960</u>													
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MARCH 20, 1899</u>		<b>9. AGE</b> (In years lost birthday) <u>71</u> yrs <table border="1"> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min</th> </tr> <tr> <td><u>3</u></td> <td><u>0</u></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min	<u>3</u>	<u>0</u>		
Months	Days	Hours	Min														
<u>3</u>	<u>0</u>																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN FARM</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>TREGO WASH. CO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>GEORGE E. NORRIS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY ELLEN GLOSS</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220-30-9374</u>		<b>17. INFORMANT</b> <u>MRS. NANNIE NORRIS - GAPLAND MD.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>									
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 10, 1960</u> <b>to</b> <u>June 20, 1960</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>June 17, 1960</u> , <b>and that death occurred at</b> <u>4 P.M.</u> <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>G. W. LeVan</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>G. W. LeVan</u>		<b>22b. DATE SIGNED</b> M D <u>20</u> <u>60</u>		<b>22d. ADDRESS</b> <u>Boonsboro, Md.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>JUNE 24, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PLEASANT VIEW CEMETERY</u>		<b>23d. LOCAT ON</b> (City, town, or county) (State) <u>BURKETTSVILLE FRED. CO. MD.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Post</u>				<b>ADDRESS</b> <u>BOONSBORO MD.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUN 22 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									



7406

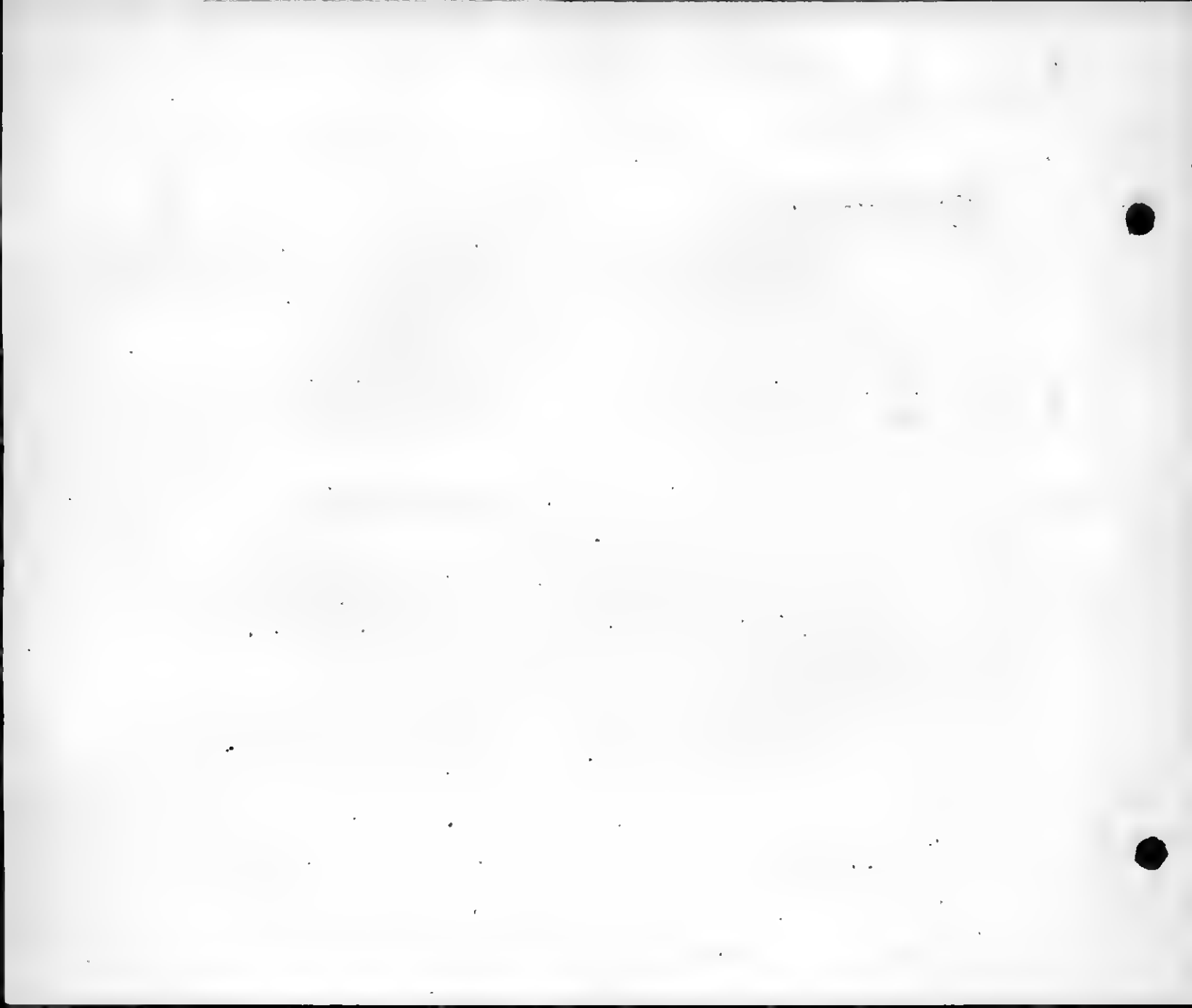
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>12 YRS.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		e. STREET ADDRESS <b>411 MITCHELL AV E.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALICE VIRGINIA OREN</b>		4. DATE OF DEATH <b>JUNE 25 19 60</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/27/1873</b>		9. AGE (In years last birthday) <b>87 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JEREMIAH STILL</b>		14. MOTHER'S MAIDEN NAME <b>MARY McCORMICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		INFORMANT <b>MR. JERRY M. OREN</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Gen</b> DUE TO <b>Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial Enlargement</b> (b) <b>Myocardial Enlargement</b> (c) <b>Myocardial Enlargement</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 2 min 24 sec</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Heart Fern - obstructive small bowel</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>June 24</b> , 19 <b>60</b> to <b>June 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>60</b> , and that death occurred at <b>119 E. Antietam</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis G. Gratt</b> M.D.		ADDRESS (Street, city or town, state) <b>119 E. Antietam Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Louis G. Gratt</b>		DATE SIGNED <b>6/25/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>THREE CHURCH HILL CEM.</b>	
22d. LOCATION (City, town, or county) <b>MATINS CRK</b>		(State) <b>PENNA.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

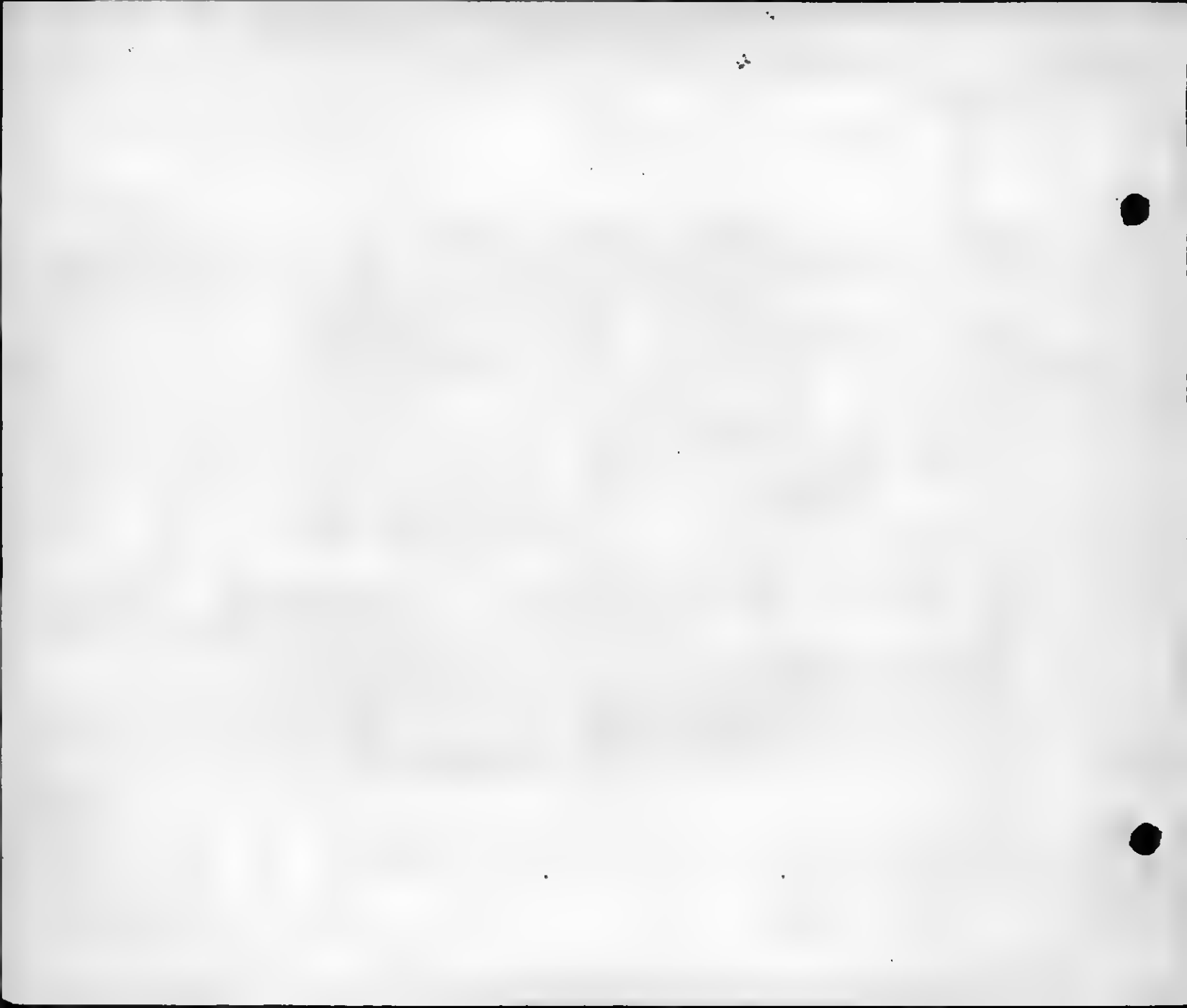
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07408

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 HAGERSTOWN</u>	
c. LENGTH OF STAY IN 1b <u>ELEVEN YEARS</u>		d. STREET ADDRESS <u>1004 SALEM AVENUE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1004 SALEM AVENUE</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALDINE D PALMER</u>		4. DATE OF DEATH <u>JUNE - 18 - 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-17-1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u>	
11. IF UNDER 24 HRS: Hours <u>1</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD. U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR - HAGERSTOWN SHOE CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEAR MYERSVILLE FIBER CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD. U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD PALMER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. KOOGLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>14-09-5783</u>	
17. INFORMANT <u>MRS. NAOMI PALMER</u>		Address <u>1004 SALEM AVE. HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gunshot wound Head</u>			
DUE TO (b) <u>776X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
(b) <u>Depressive Reaction</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted wound at temporal Area</u>	
20c. TIME OF INJURY Month, Day, Year <u>6 20 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 21 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Baer</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

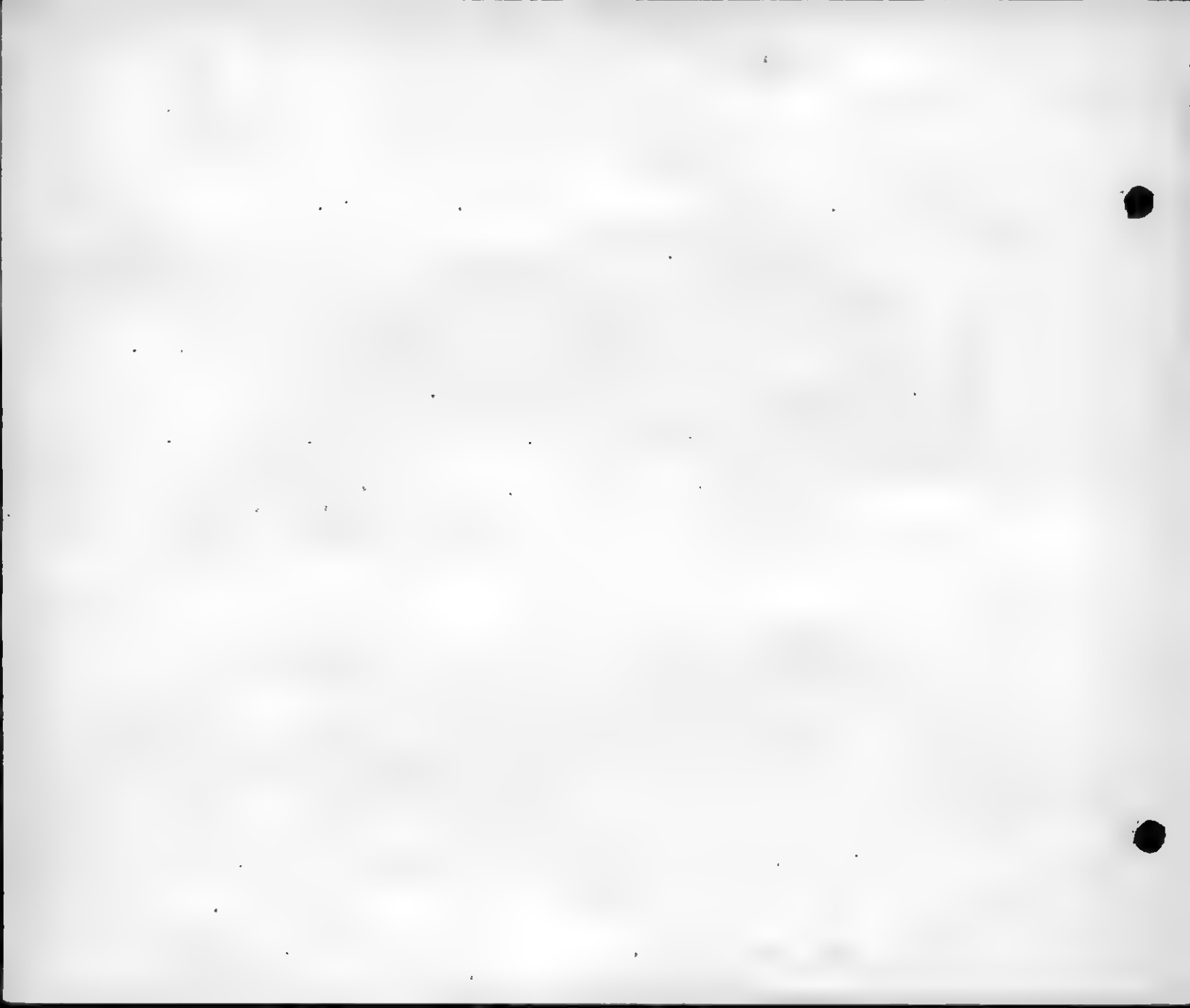
7408

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND

CERTIFICATE OF DEATH

07409

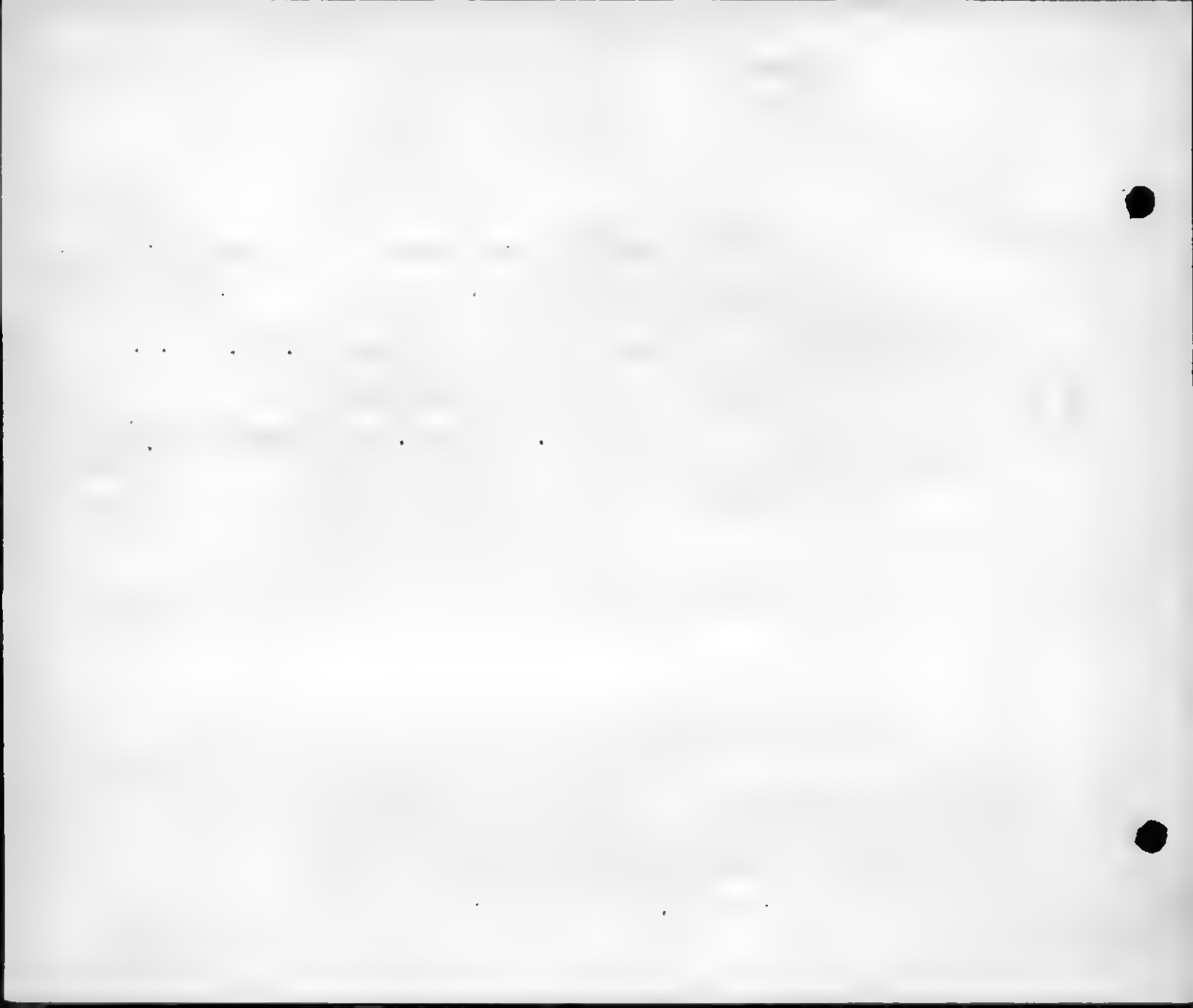
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>30 YEARS</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASH.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		d. STREET ADDRESS <b>38 N. POTOMAC ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN I. PHELPS</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAY 30, 1905</b>	9. AGE (In years last birthday) <b>55</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD J. HEEFNER</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE M. ODEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>161-12-0444</b>		17. INFORMANT <b>MRS. MARY GEIST III</b> Address <b>4 S. POTOMAC ST. HAGERSTOWN, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic CARCINOMA of Lungs</b> DUE TO <b>Adenocarcinoma of Breast, Rt.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>1 yr +</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9, 1959</b> to <b>June 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1960</b> , and that death occurred at <b>320A</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Richard V. Hauver</b>		22b. DATE SIGNED <b>June 24, 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>RICHARD V. HAUVER</b>	
22d. ADDRESS <b>247 N. Potomac St. Hagerstown, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/27/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>	
23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN, MD.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>FRED W. KRAISS</b>		ADDRESS <b>HAGERSTOWN, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hauer</b>					



may be returned by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7409 CERTIFICATE OF DEATH 07410

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>Sharpsburg</b>			
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Colbert</b> Last <b>Poffenberger</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11 1888</b>	9. AGE (In years last birthday) <b>72</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>16</b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Knotts Quarry W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Benjamin Colbert</b>				14. MOTHER'S MAIDEN NAME <b>Anna Grey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Thomas R. Poffenberger</b>		Address <b>Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infection Left Kidney</b> DUE TO (b) <b>Thrombosis left Renal Artery</b> DUE TO (c) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility -</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>20 June 1960</b> to <b>27 June 1960</b> that (I) (we) last saw the deceased alive on <b>27 June 1960</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank E. Brumback</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Frank E Brumback</b>				22d. ADDRESS <b>170 West Washington St</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William G. Smith</b>				25a. REC'D BY REG. STRAR DATE <b>JUL 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

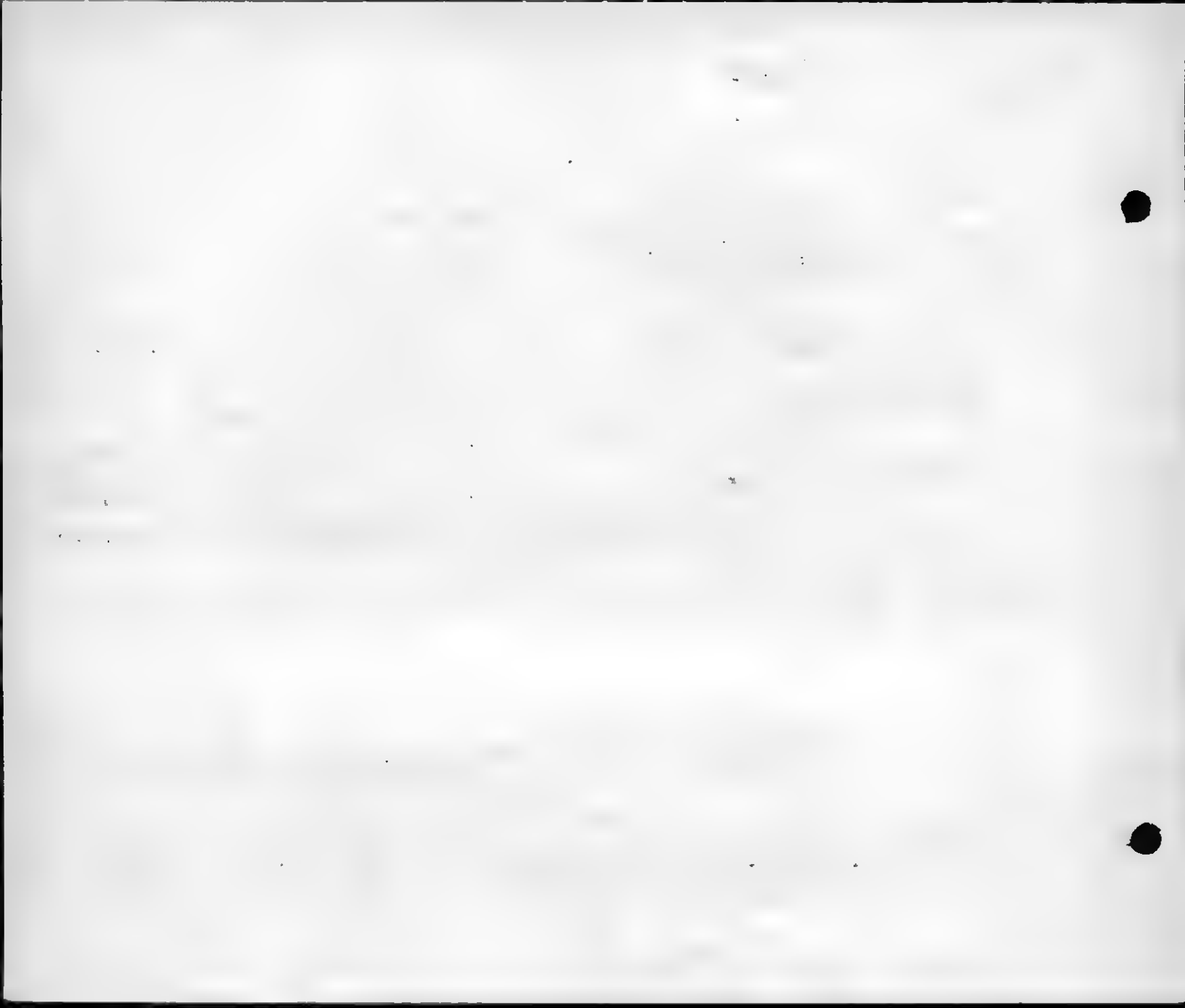
VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7410  
CERTIFICATE OF DEATH

07411

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>25 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WESTERN MD. STATE HOSPITAL</b>		d. STREET ADDRESS <b>214 SUMMIT AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Millard</b> Middle <b>Guy</b> Last <b>POOLE</b>		4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work-no life, even if retired) <b>RETIRED OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE STATION</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAHAM L. POOLE</b>		14. MOTHER'S MAIDEN NAME <b>MAMIE TOMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-09-7133</b>	
17. INFORMANT <b>MR. ROY POOLE</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>180X</b> IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Hypertrophied heart with generalized carcinomatous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Broncho pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 8, 1960</b> to <b>June 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1960</b> and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Young E. Chun</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Young E. Chun</b>		22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/16/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REFORMED CHURCH CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>MIDDLLETOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Hornum, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>			

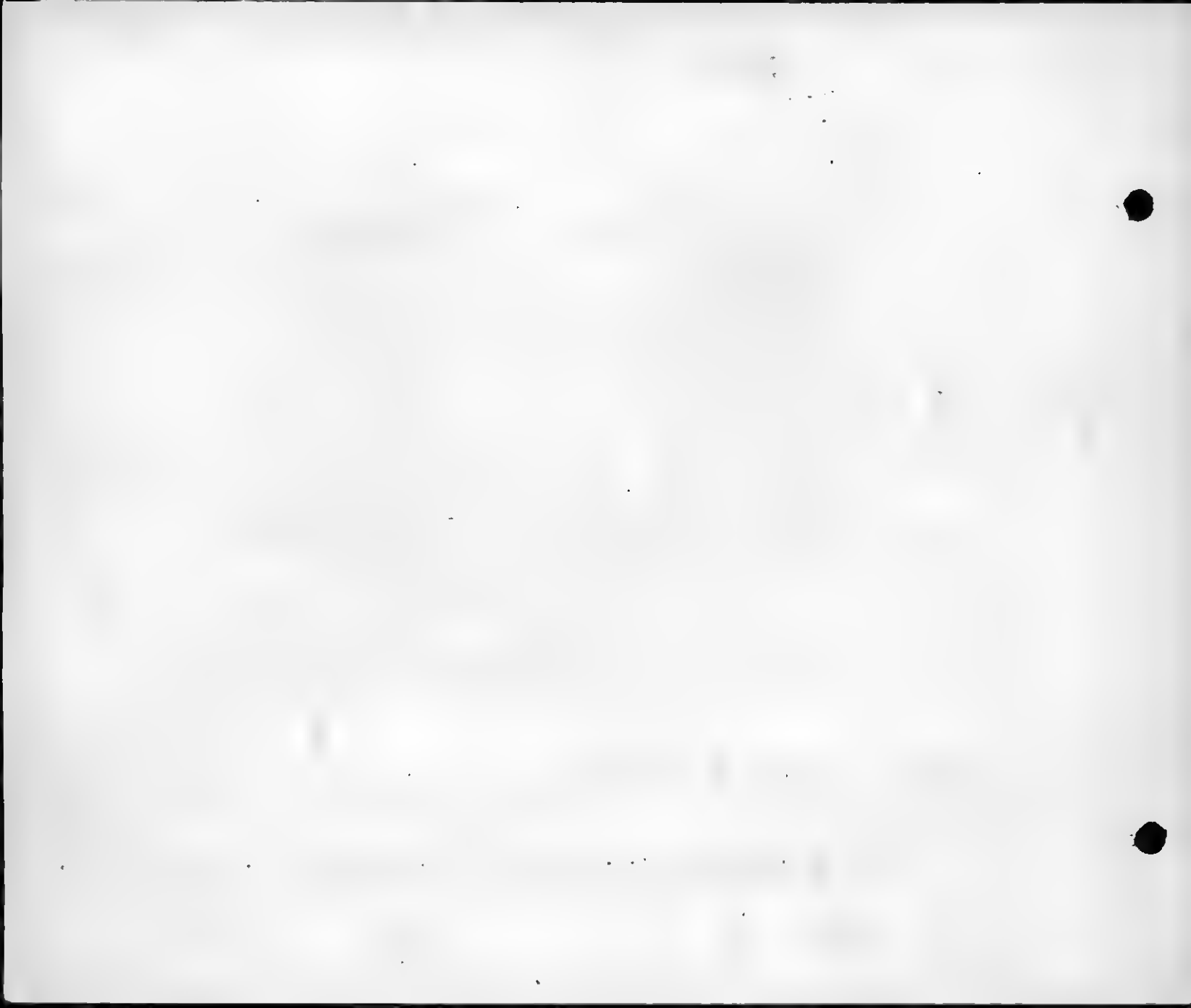


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7411  
CERTIFICATE OF DEATH

07412

1 PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>12 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>MT. BRIER - RURAL</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES T REESE</u>				4 DATE OF DEATH Month Day Year <u>JUNE - 28 - 1960</u>			
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUG. 28 - 1876</u>	9 AGE (In years last birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months Days Hours Min <u>10 0</u>	IF UNDER 24 HRS.	10 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u>				10b KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>			
11 BIRTHPLACE (State or foreign country) <u>MT. LEAH WASH. CO. MD. U.S.A.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>EZRA REESE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA ARNOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-20-824</u>			
17 INFORMANT <u>MRS. ELSIE M. REESE</u>				Address <u>KEEDYSVILLE MD R.I.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u>							<u>1 day</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u>							<u>5 yrs.</u>
(c) <u>arteriosclerosis</u>							<u>1 yr -</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town)		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1957</u> to <u>June 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1960</u> , and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above.							
22a SIGNATURE <u>Philip J. Hirshman</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>6/28/60</u>	
22c PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				22d ADDRESS <u>159 W. Washington St., Hagerstown, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>July-1-1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD.</u>		25a REC'D BY REGISTRAR <u>JUL 5 '60</u>	
				25b REGISTRAR'S SIGNATURE <u>Clifford S. Kline</u>			

159-W. WASH. ST. HAGERSTOWN, MD.





TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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7412

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7412

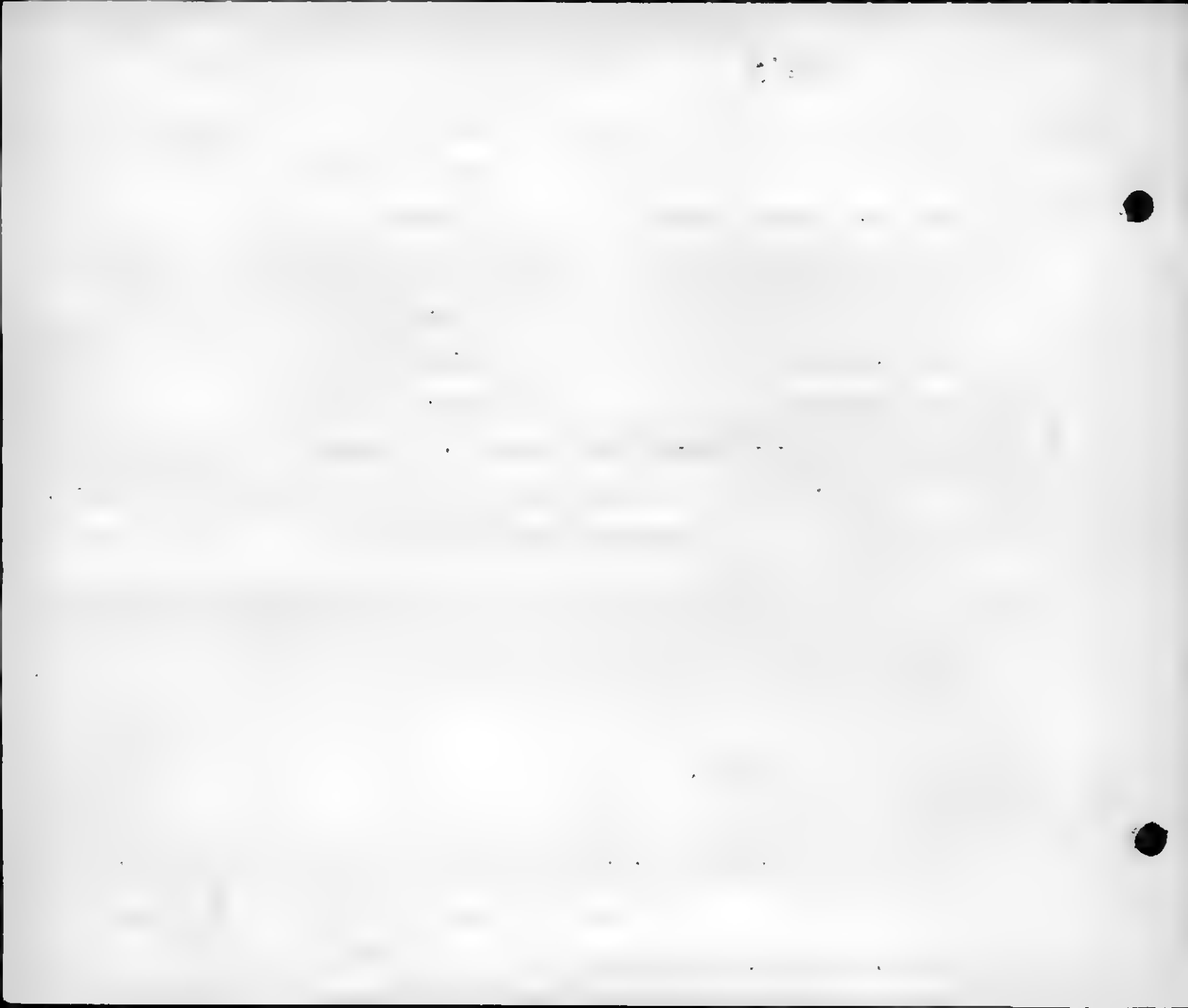
CERTIFICATE OF DEATH

302

07413

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#3</b>			
c. LENGTH OF STAY IN 1b <b>2 Hrs</b>				d. STREET ADDRESS <b>Funkstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLSWORTH ROHRBACK ROULETTE</b>				4. DATE OF DEATH Month Day Year <b>June 16, 1960 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 26, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President, Nicodemus Bank</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sharpsburg Wash Co Md</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Roulette</b>				14. MOTHER'S MAIDEN NAME <b>Annie Rohrback</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-20-2818</b>			
17. INFORMANT <b>Robert E. Roulette, Hagerstown R#3 Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 hours.</b> Years.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>June 16, 1960</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1960</b> , to <b>June 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 16, 1960</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>R. A. Bell</b>				22b. DATE SIGNED <b>June 18, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M.D.</b>				22d. ADDRESS <b>Hagerstown, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/18/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md</b>				25a. REC'D BY REGISTRAR <b>JUN 20 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

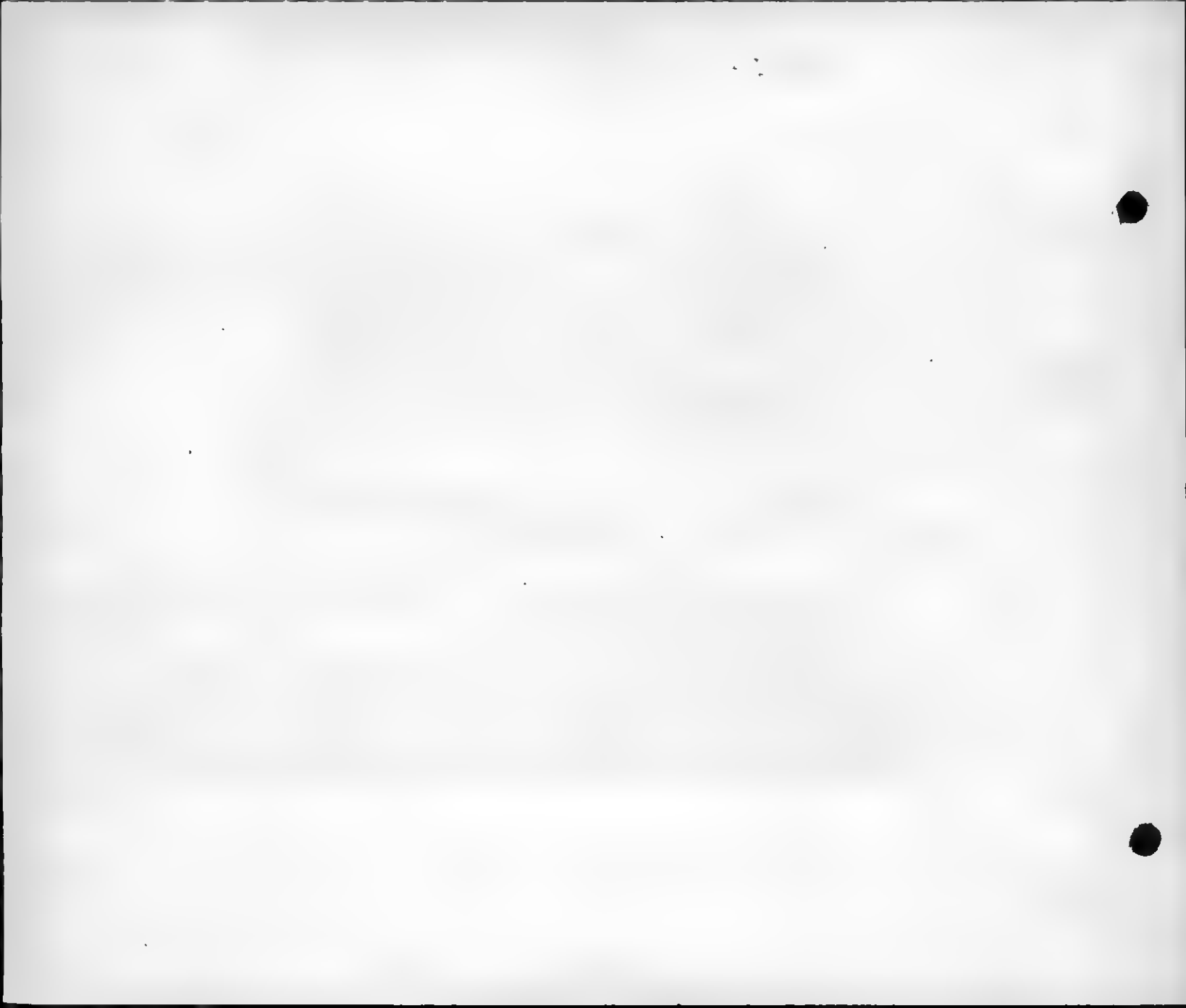


TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7413 CERTIFICATE OF DEATH 07414

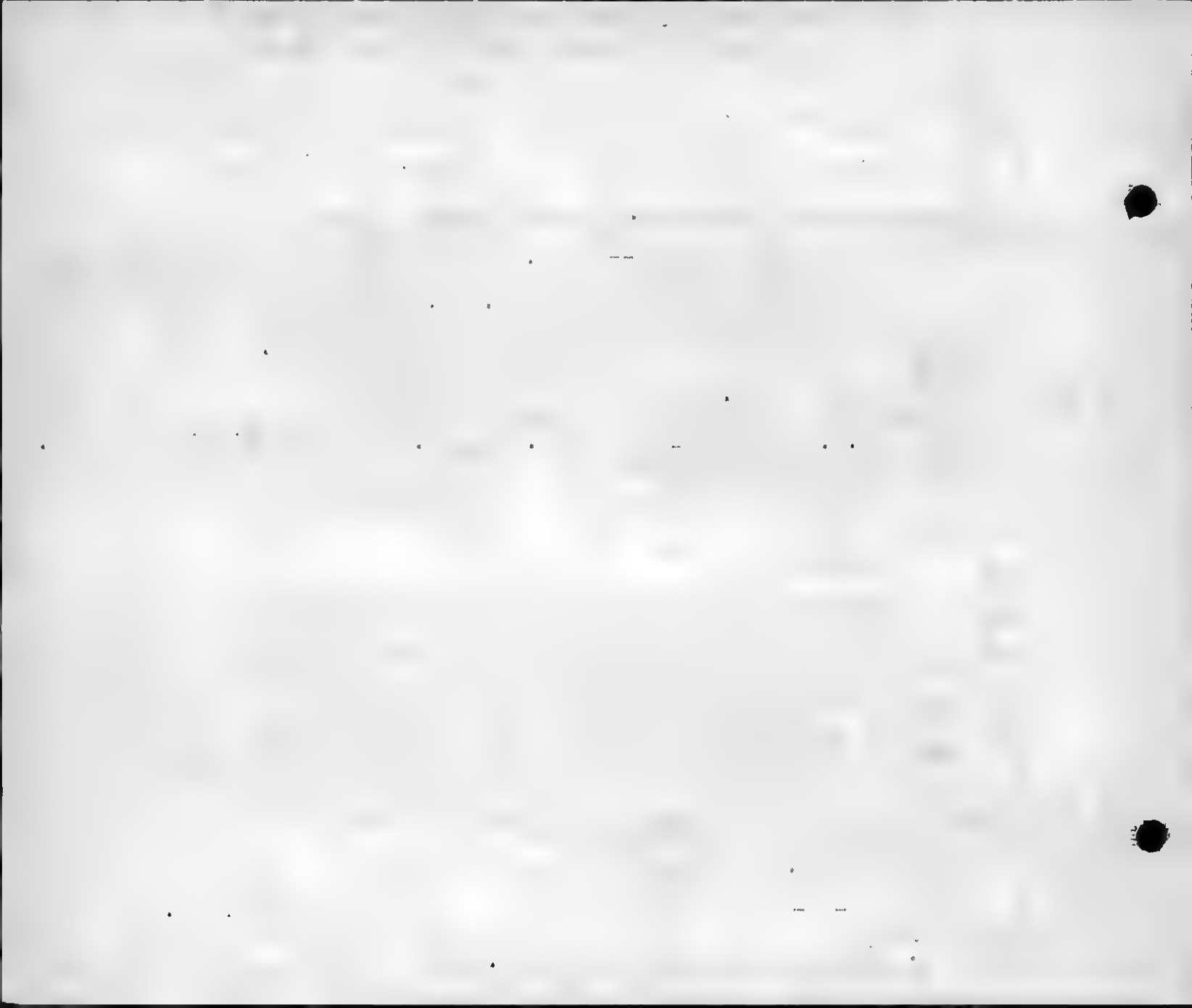
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN MD.</u>		c. LENGTH OF STAY IN 1b <u>Boonsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MD. STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Elizabeth Russler</u>		4. DATE OF DEATH Month Day Year <u>June 28, 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31 - 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 28</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. BIRTHPLACE (State or foreign country) <u>Boonsboro WASH. Co. MD.</u>	
13. FATHER'S NAME <u>SAMUEL MEREDITH</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE FLOOK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>101</u>	
17. INFORMANT <u>JOHN T. RUSSLER</u>		Address <u>Boonsboro MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lobular pneumonia, bilateral</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>carcinomatosis</u> DUE TO (c) <u>carcinoma of the breast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1960</u> to <u>June 28, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1960</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u> M.D.		22b. DATE SIGNED <u>June 28, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>		22d. ADDRESS <u>Western Md. State Hospital, Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 30, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Boonsboro WASH. Co. MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 5 '60</u>	
ADDRESS <u>Boonsboro MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07415									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Williamsport				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rear of 615 Elizabeth Ave.					d. STREET ADDRESS 1 Route 2				
3. NAME OF DECEASED (Type or print) First Richard Middle --- Last St. Clair					4. DATE OF DEATH Month June Day 19 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1926		9. AGE (in years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crator		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Oscar St. Clair				14. MOTHER'S MAIDEN NAME Ruth Cave					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11		17. INFORMANT Address Mrs. Ruth V. St. Clair Williamsport Tr. 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.5 DUE TO Respiratory Distress Conditions, if any, which gave rise to immediate cause (b) Acute alcoholic intoxication (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Ac. Alconol intoxication - lay on back seat of car - vomited and aspirated vomitus							
20c. TIME OF INJURY Month, Day, Year Hour 6 19 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St.		20f. (City or town) Hagerstown		(County) Wash	
								(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Edward W. Ditto III M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Edward W. Ditto III					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMAINS (ALSO TYPE)		22b. DATE THEREOF 6-21-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn		22d. LOCATION (City, town, or county) Hagerstown Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son					ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7414

CERTIFICATE OF DEATH

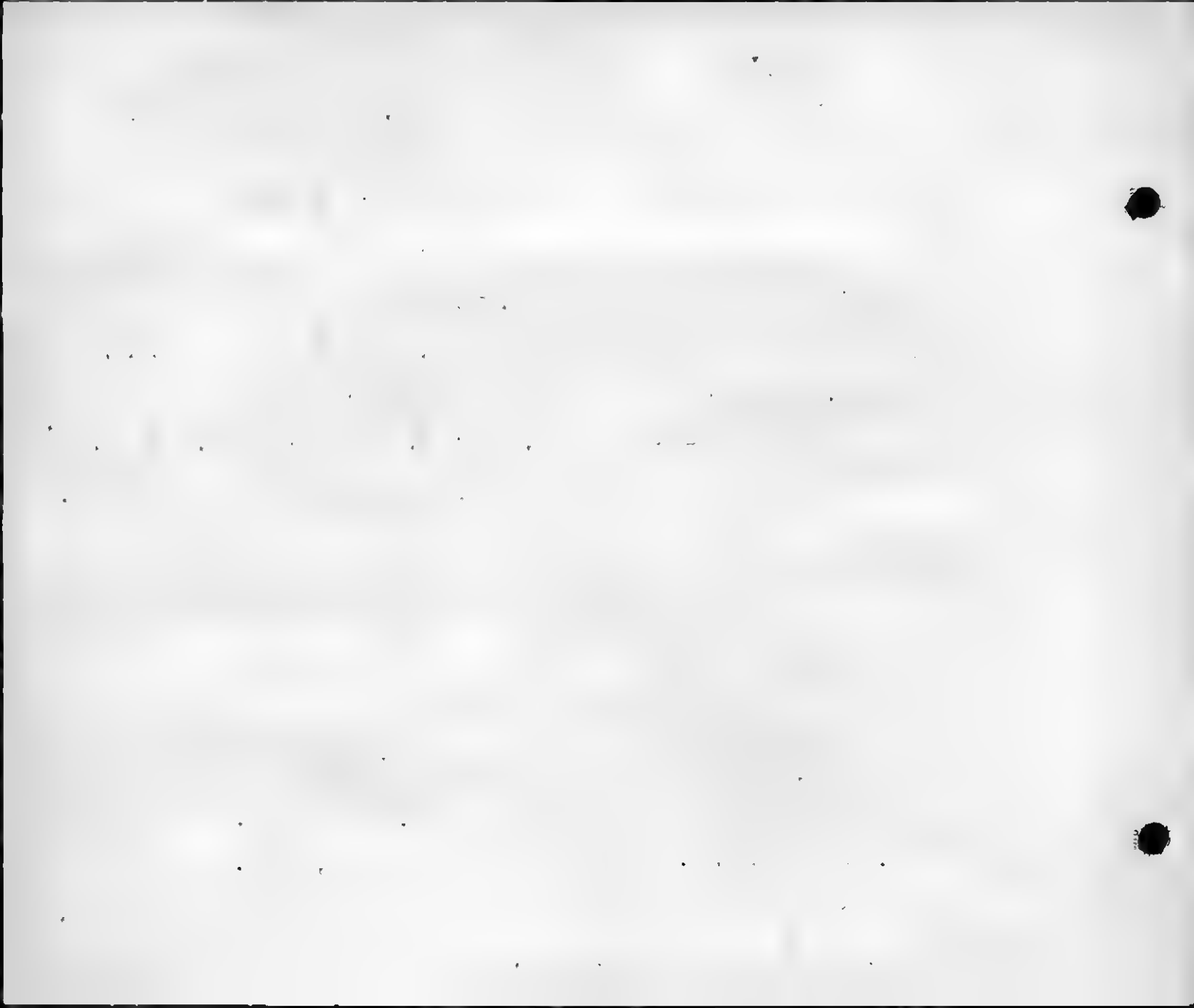
07416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>306 West Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>R</b> Last <b>Schaeffer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1886</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob W. Schaeffer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Reeder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>186-28-2737</b>	
17. INFORMANT <b>Mrs. Neadia P. Schaeffer</b>		Address <b>Waynesboro, Pa. 306 W. Main St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Reticulum cell sarcoma, retroperitoneal</b> 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1940</b> to <b>June 10, 1960</b> , that I last saw the deceased alive on <b>June 10, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. C. Brewer</b>		ADDRESS (Street, city or town, state) <b>359 E. Baltimore St.</b>	
PHYSICIAN'S NAME (Type) <b>W. C. Brewer, M. D.</b>		DATE SIGNED <b>6/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>
22d. LOCATION (City, town, or county) <b>Waynesboro</b>		(State) <b>Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Marlin Poe</b>		ADDRESS <b>Waynesboro, Penna.</b>	
24a. REC'D BY REGISTRAR <b>JUN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

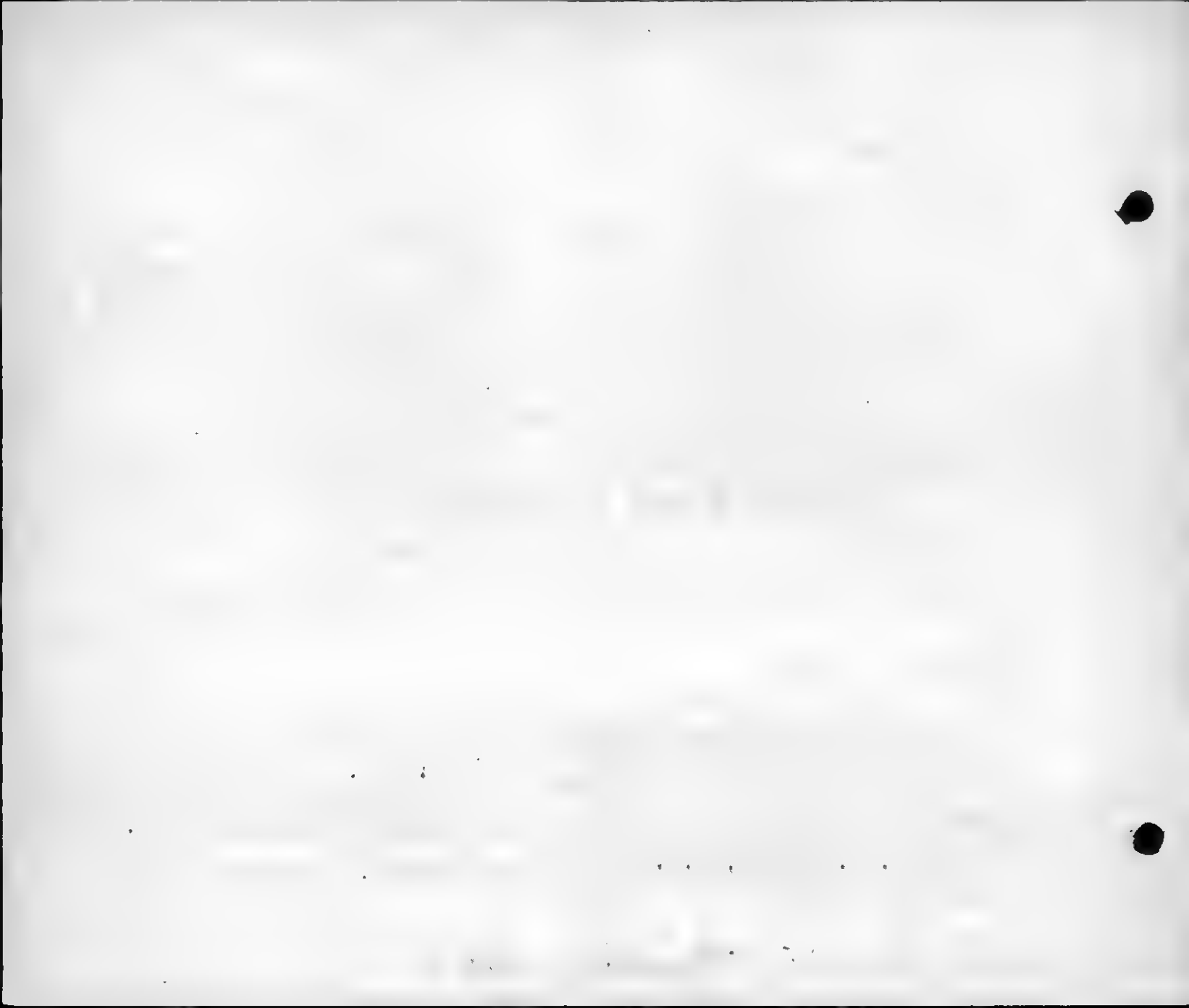
7415  
CERTIFICATE OF DEATH

07417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>40 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>MONROE</b> Last <b>SHAFFER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PLUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING REPAIR CO.</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
13. FATHER'S NAME <b>WILLIAM H. H. SHAFFER</b>		14. MOTHER'S MAIDEN NAME <b>PHIANNA RHODES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>214-09-2794A</b>	
17. INFORMANT <b>MRS. DOROTHY SHAFFER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19 60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 2</b> 19 <b>60</b> to <b>June 6</b> 19 <b>60</b> , that I last saw the deceased alive on <b>June 5</b> 19 <b>60</b> , and that death occurred at <b>12:45am</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg.</b> DATE SIGNED <b>6/8/60</b> ACTUAL SIGNATURE <b>W. T. Layman</b> M.D. PHYSICIAN'S NAME (Type) <b>W. T. Layman, M.D.</b> <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/8/60</b>	22b. DATE THEREOF <b>BURIAL</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CLM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Layman, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. H...</b>

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be relied on by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

7416

CERTIFICATE OF DEATH

7416

07418

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown (Rural)</b>			
c. LENGTH OF STAY IN 1b <b>8 Hrs.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>RFD #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Debra Lee Shank</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1 1960</b>	
9. AGE (In years lost birthday) yrs <b>8</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dale Lee Shank</b>				14. MOTHER'S MAIDEN NAME <b>Betty Maugans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Dale Lee Shank Hagerstown Md RFD #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>25.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mongolism a congenital defect of heart</b> DUE TO (c) <b>of heart</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 Hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a)							19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-1-1960</b> to <b>6-1-1960</b> , that (I) (we) last saw the deceased alive on <b>6-1-1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles F. Hess</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>				22d. ADDRESS <b>Smithsburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 3-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf Williamsport, Md</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 6 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

208181XV4



7411

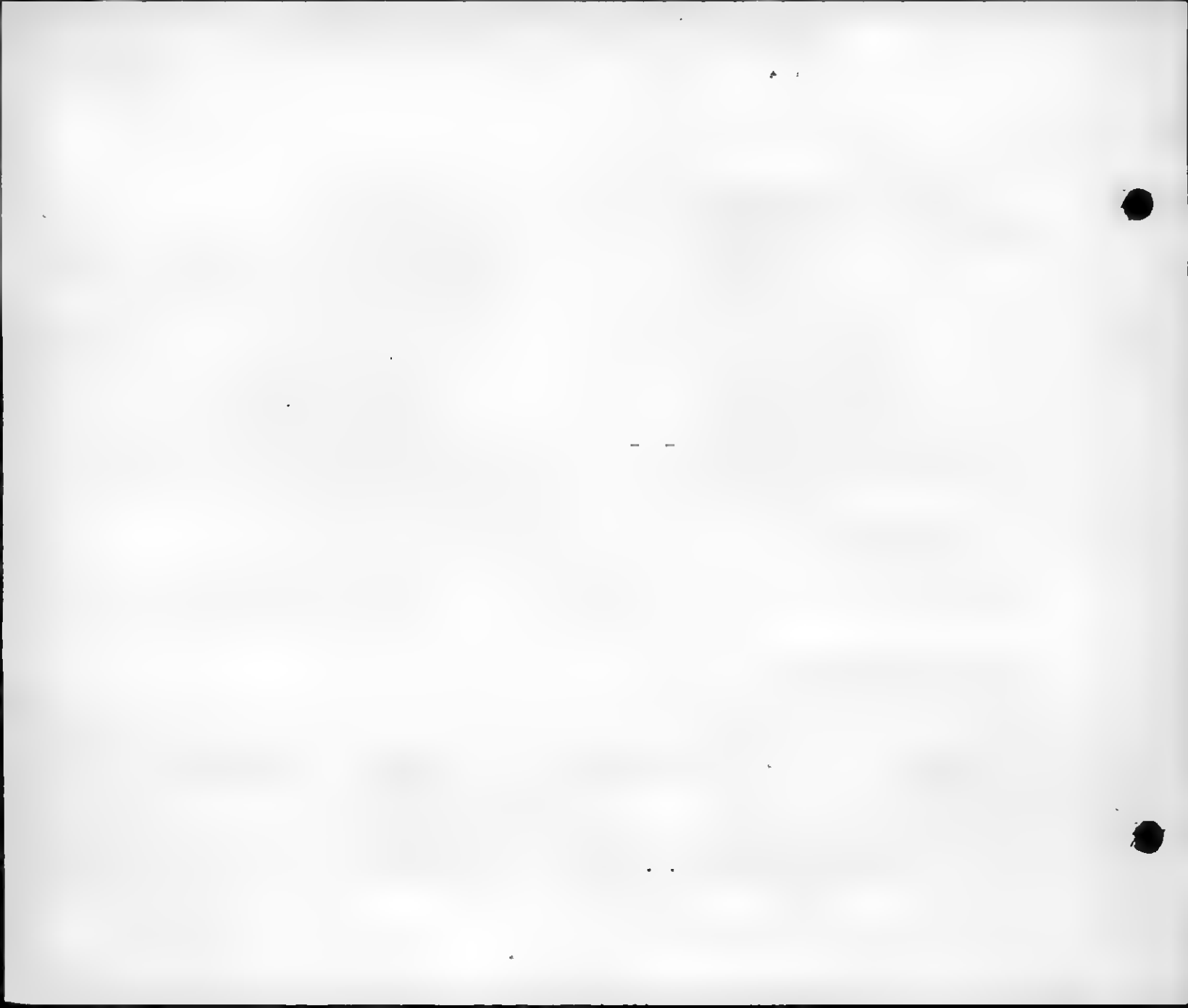
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07419

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>664 OAK RIDGE DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE SHANTZ</b>				4. DATE OF DEATH Month Day Year <b>JUNE 6 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 12 1896</b>		9. AGE (In years lost birthday) <b>63</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FREIGHT CONDUCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>GEORGE SHANTZ</b>				14. MOTHER'S MAIDEN NAME <b>BESSIE LINEBAUGH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>719-05-6263</b>		17. INFORMANT <b>HARRY Y SHANTZ RT #4 HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aneurism of Abdominal Aorta. Hypertrophy of Prostate</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> <b>1958</b> to <b>June 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>6-5</b> <b>1960</b> , and that death occurred at <b>8:30</b> AM, from the causes and on the date stated above							
22a. SIGNATURE <b>Robert P. Conrad</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>6-6-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT P CONRAD M.D.</b>				22d. ADDRESS <b>Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. SISTER ROBERT'S FUNERAL HOME <b>Charles M. Rouzer</b>				ADDRESS <b>HAGERSTOWN MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**1**

## 07420

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS <b>Rural 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thornton John Shoemaker</b>		4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.8.1883</b>	9. AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Shoemaker</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McCarty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-9146</b>		17. INFORMANT <b>Mrs Leathia Shoemaker Rural 2 Hancock Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>1512</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lacerating Stomach</b> DUE TO (c) <b>Smile</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 da</b> <b>14 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/25/60</b> to <b>6/1/60</b> that (I) (we) last saw the deceased alive on <b>6/1/60</b> and that death occurred at <b>PA</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>L M Shaffer</b>		22b. DATE SIGNED <b>6/1/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L M SHAFER</b>		22d. ADDRESS <b>Hancock, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6.4.60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brethern Rural Hancock Washington Md</b>	
23d. LOCATION (City, town, or county)		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Houard &amp; Stone Hancock Md</b>		25a. REC'D BY REGISTRAR <b>JUN 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	





may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

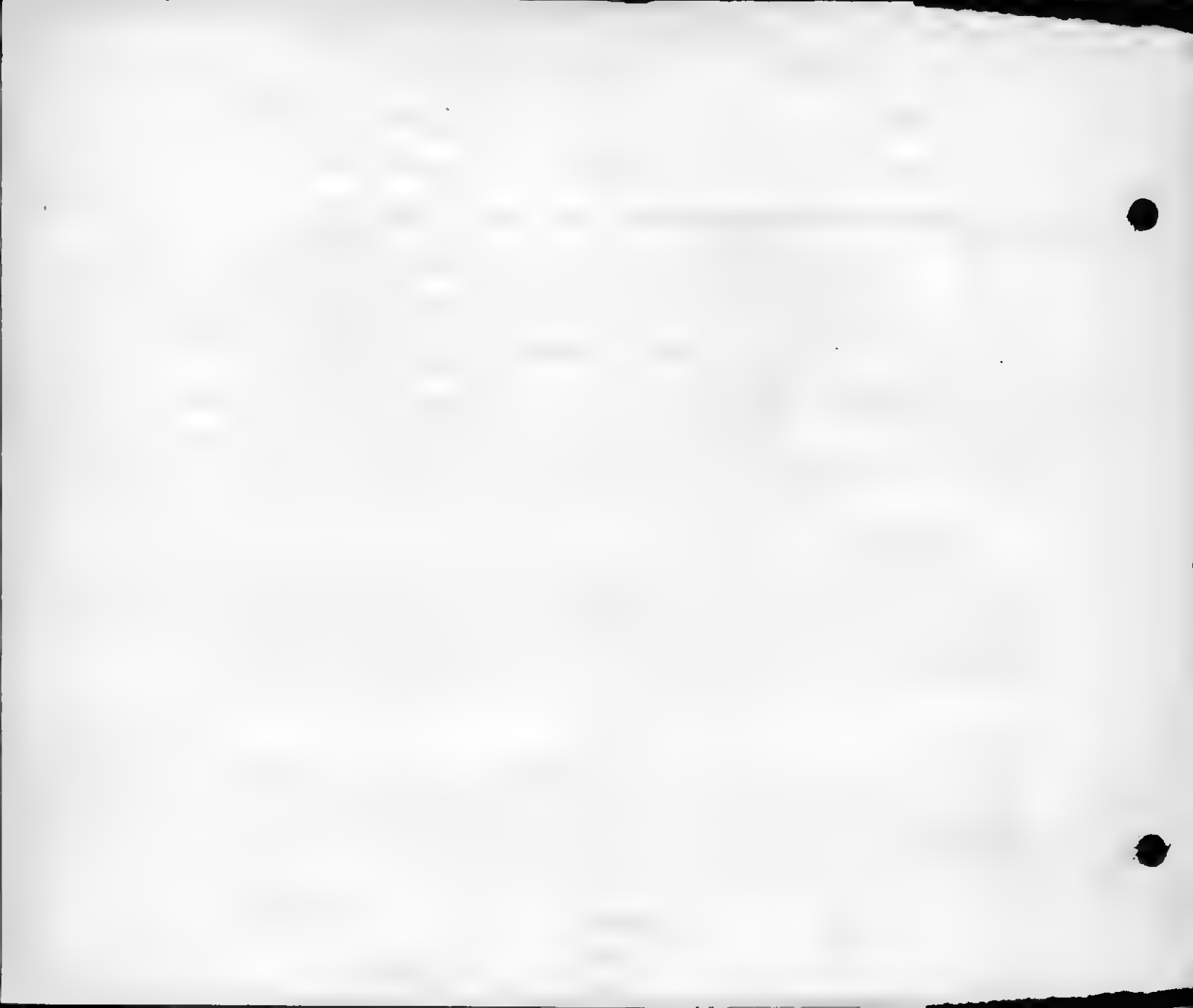
DR. SECONDARY

7427

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07421

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDER NURSING HOME</u>				e. STREET ADDRESS <u>113 JOHN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARLAN WINFIELD SMITH</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 12, 1960</u>			
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL - 8 - 1880</u>	9 AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>	IF UNDER 24 HRS Hours <u>4</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED POLICEMAN HAGERSTOWN CITY PARK</u>				10b KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD. U.S.A.</u>			
11. BIRTHPLACE (State or foreign country)				12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>OTHLO SMITH</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE HORINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-18-2146</u>			
17. INFORMANT <u>HERBERT W. SMITH</u>				Address <u>HAGERSTOWN MD.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> 491X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21 I certify that (I) (this hospital) attended the deceased from <u>June 2, 1960</u> to <u>June 12, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1960</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>J. Secondary</u>				22b DATE SIGNED <u>June 12, 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>				22d. ADDRESS <u>BOONSBORO MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JUNE 15, 1960</u>			
23c NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				23d. LOCATION (City, town, or county) <u>BOONSBORO WASH. CO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				25a REC'D BY REGISTRAR <u>DATE JUN 17 60</u>			
ADDRESS <u>BOONSBORO MD.</u>				25b REGISTRAR'S SIGNATURE <u>C. H. &amp; K. H.</u>			



may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

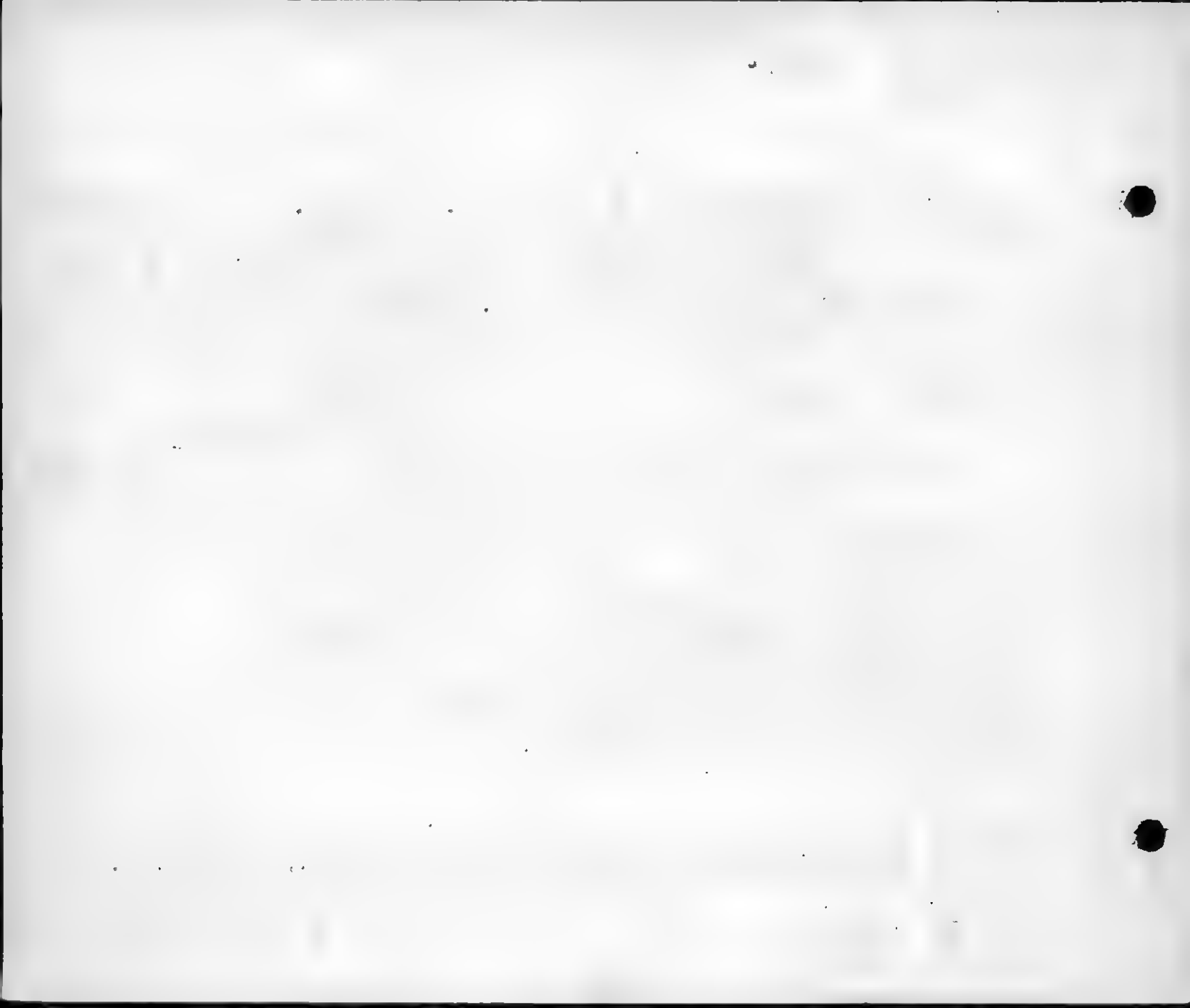
CERTIFICATE OF DEATH

07422

7418 Item 8 Baltimore 6-8-60

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washingtonn County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JULIA</b> Last <b>SOCKS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26 1914</b>	
9. AGE (In years last birthday) <b>45</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State of foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>WILLIAM DIDDLEBOCK</b>				14 MOTHER'S MAIDEN NAME <b>MARY SOCKS</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Robert H Socks</b>		Address <b>Cumberland Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>Postoperative atelectasis and pneumonia</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Postoperative atelectasis and pneumonia</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>5-15-60</b> to <b>6-1-60</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>5-31-60</b> 19 <b>60</b> , and that death occurred at <b>2:15 A</b> M, from the causes and on the date stated above.							
22a SIGNATURE <b>Paul Harrison</b>				22b ADDRESS <b>318 N. Potomac St., Hagerstown, Md.</b>		22c PHYSICIAN'S NAME (Type) <b>Paul Harrison M D</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>6/4/60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24a SIGNATURE OF REGISTRAR <b>Charles M Rouzer</b>				25a REC'D BY REGISTRAR DATE <b>JUN 6 '60</b>		25b REGISTRAR'S SIGNATURE <b>Arthur S. France</b>	

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

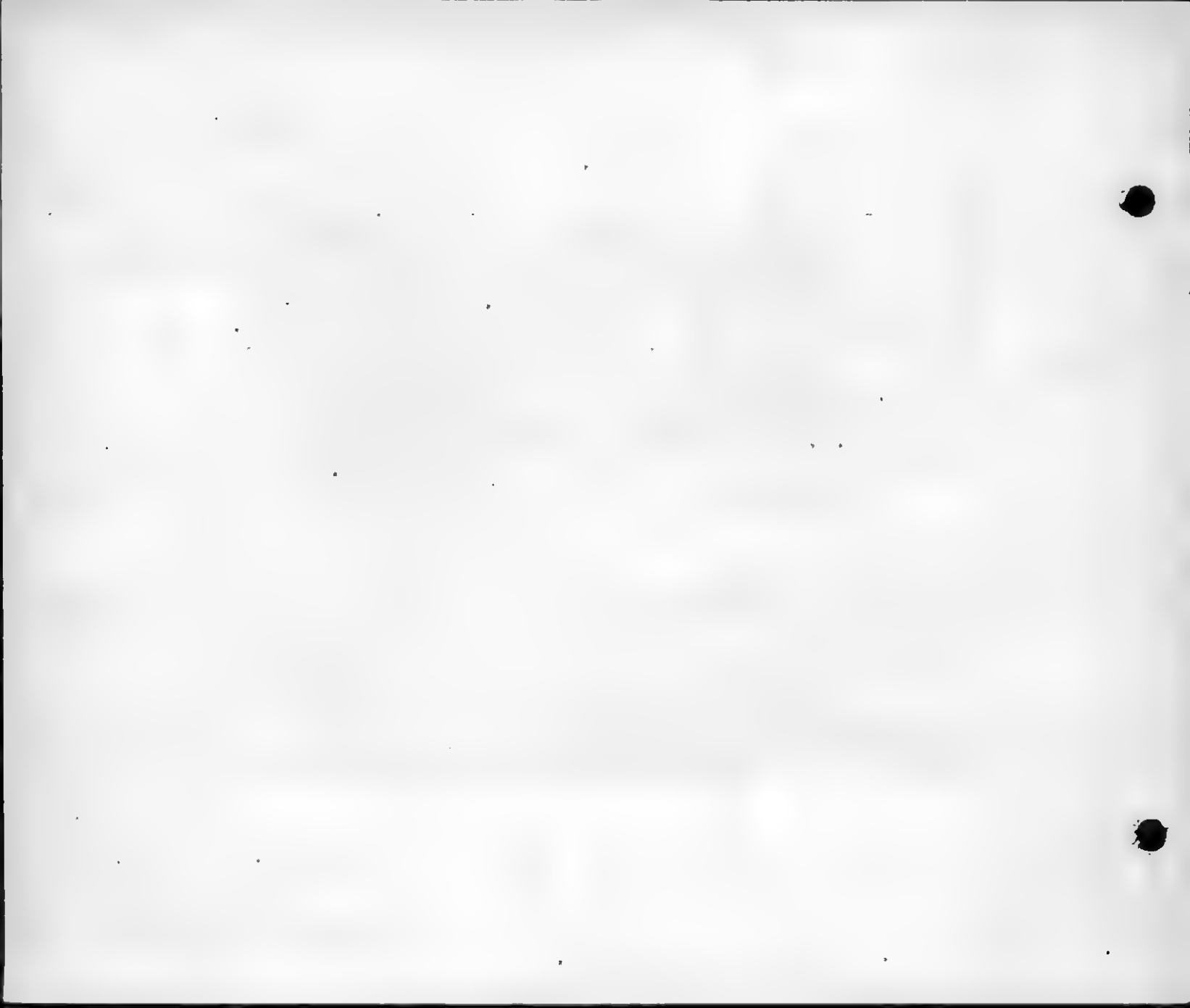
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7419

302

07423

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>10 Mi.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>88 West Lee St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT WILSON SOUTH</b>				4. DATE OF DEATH <b>June 7 1960</b> 19			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Apr. 16 1918</b>		9. AGE (In years lost birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern Operator Funkstown Wash Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roy O. South</b>				14. MOTHER'S MAIDEN NAME <b>Naomi Knott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.# 3 320-05-6109</b>		17. INFORMANT <b>Mrs Dorothy South 3100 Hillandale Rd</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>July 19, 1957</b> to <b>June 7, 1960</b> that (I) (we) last saw the deceased alive on <b>June 6, 1960</b> , and that death occurred at <b>8:15 P</b> on the causes and on the date stated above							
22a. SIGNATURE <b>R. A. Bell</b>				22b. DATE SIGNED <b>June 9, 1960.</b>		22c. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M.D.</b>	
22d ADDRESS <b>Hagerstown, Maryland.</b>							
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d LOCAT ON (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>JUN 13 '60</b>		25b REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7421  
CERTIFICATE OF DEATH

07424

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Route#4</b> d. STREET ADDRESS <b>Cearfoss</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jacob Roman Stockslager</b>		4. DATE OF DEATH <b>June 23 1960</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21 1882</b> yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob R. Stockslager</b>		14. MOTHER'S MAIDEN NAME <b>Mary Eliz Winter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Raymond W. Stockslager</b>		Address <b>Hagerstown Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <b>420</b> DUE TO <b>Alumina</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis + Prostatic obst.</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>chronic</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>25 July 1951</b> to <b>23 June 1960</b> , that (I) (we) last saw the deceased alive on <b>23 June 1960</b> , and that death occurred at <b>8:14 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard T. Binford</b>		22b. DATE SIGNED <b>24 JUNE 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>		22d. ADDRESS <b>1135 POTOMAC AVENUE, HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07425

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Md</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Little Pool Near Hancock Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1 Hancock Maryland</u> d. STREET ADDRESS <u>Rural 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Seibert</u> Last <u>Stotler</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>5</u> Year <u>19 60</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4.23.1916</u>		<b>9. AGE</b> (In years last birthday) <u>44</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House Painting</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Morgan County W.VA.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Clarence Stotler</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Irene Waugh</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>				<b>16. SOCIAL SECURITY NO.</b> <u>2.232-26-6304</u>				<b>17. INFORMANT</b> <u>Mary F Stotler</u>				<b>Address</b> <u>Rural 1 Hancock Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850X</u> DUE TO <u>TRUNK X 18 G</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Other started in fall from foot in Little Pool (canal)</u>											
<b>20c. TIME OF INJURY</b> Month <u>6</u> Day <u>5</u> Year <u>1960</u> Hour <u>3:30</u> a.m. <u>  </u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Canal</u>				<b>20f. (City or town)</b> <u>Hancock Washington Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>E. W. Stotler</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>6/5/60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>E. W. Stotler</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>6.8.60</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Morgan County W.VA.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. H. Stotler</u>						<b>ADDRESS</b> <u>Hancock Md</u>						<b>24a. REC'D BY REGISTRAR</b> <u>  </u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Pages may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

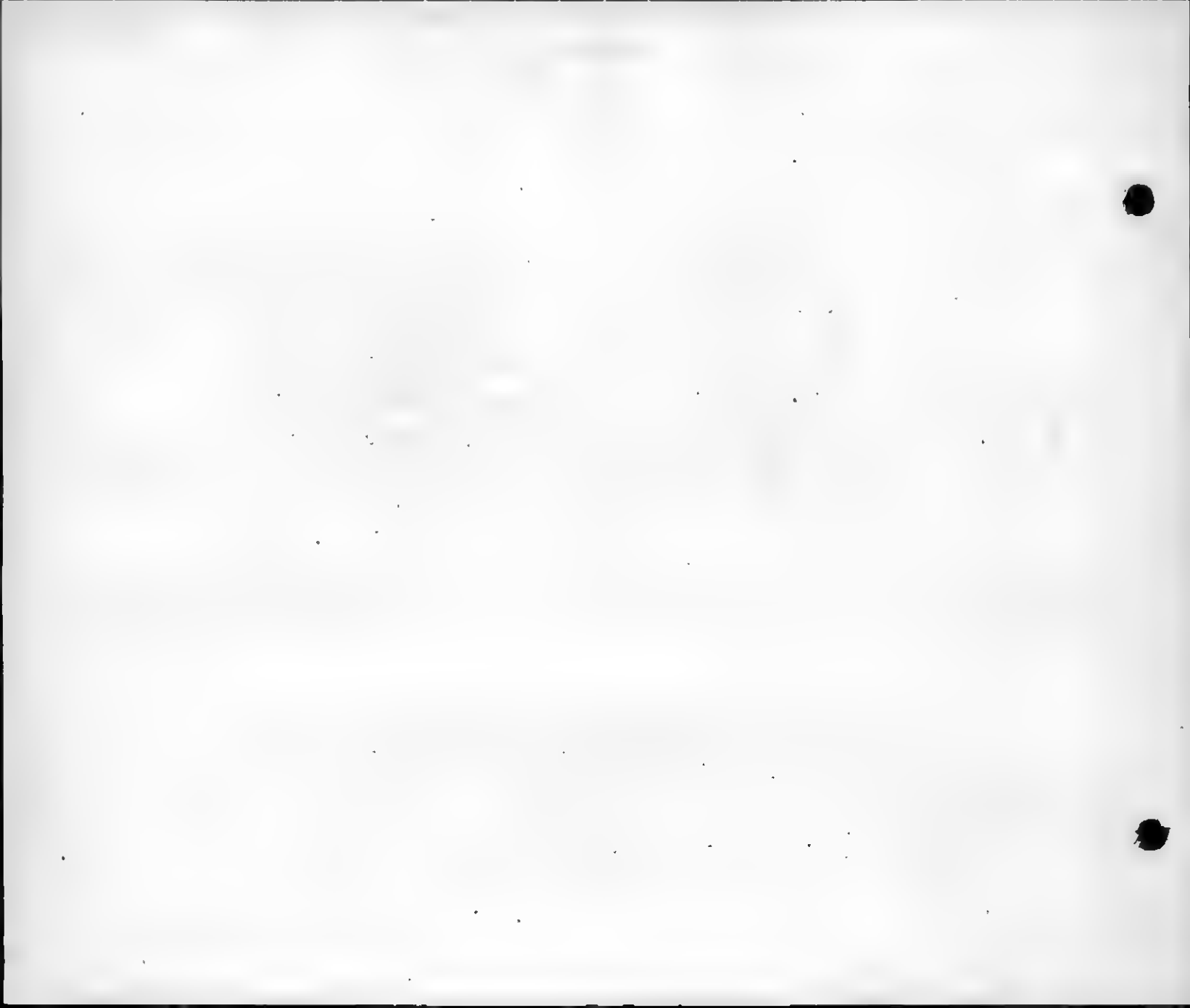
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07426

7447  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b> d. STREET ADDRESS <b>Route 2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>C.</b> Last <b>Stottlemeyer</b>		4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/24/1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>7</b> Hours <b>10</b> Min.	IF UNDER 24 HRS Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Hamilton Stottlemeyer</b>	
14. MOTHER'S MAIDEN NAME <b>Susanna Hoover</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Mary Stottlemeyer, Boonsboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Stroke of the brain</b> DUE TO (c) <b>Secondary infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1950</b> , to <b>June 14, 1960</b> , that I last saw the deceased alive on <b>June 14, 1960</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>17 D</b>			
ACTUAL SIGNATURE <b>J. J. Secord</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOSEPH SECORDARI</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/16/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company,</b> ADDRESS <b>Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(J)  
5M 9/55

Item 20 Film 2										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07427																																																											
7422										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																																																											
1. PLACE OF DEATH a. COUNTY WASHINGTON					b. CITY OR TOWN (If outside corporate limits, write RURAL) HAGERSTOWN					c. LENGTH OF STAY IN 1b 1 WEEK					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY SUFFOLK					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST ISLIP LONG ISLAND																																																											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL										d. STREET ADDRESS 163 MALTS AVE.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
3. NAME OF DECEASED (Type or print) First TINA Middle LEE Last TRUMPOWER					4. DATE OF DEATH Month JUNE Day 8 Year 19 60					5. SEX FEMALE					6. COLOR OR RACE WHITE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 9/4/1957					9. AGE (In years last birthday) 2 yrs.					IF UNDER 1 YEAR Months Days Hours Min.					IF UNDER 24 HRS.																																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country) MARYLAND										12. CITIZEN OF WHAT COUNTRY? U.S.A.																																																	
13. FATHER'S NAME LLOYD KENNETH TRUMPOWER										14. MOTHER'S MAIDEN NAME SHIRLEY BRINING										15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO										16. SOCIAL SECURITY NO. NONE										17. INFORMANT MRS. EDITH TRUMPOWER										Address HAGERSTOWN MD.																													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extra clinical hematoma due to fracture of 8 ribs. none + severe middle meningeal artery										DUE TO (b)										DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days																																																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing in yard with grandfather - fell from his arm and struck head on ground										20c. TIME OF INJURY Month, Day, Year 4 6 19 60 Hour 20:20 p. m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) About Home										20f. (City or town) Hagerstown										(County) Wash										(State) Md									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .																																																																															
ACTUAL SIGNATURE Edward W. Ditto III										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 6/8/60																																																											
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																																																											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										22b. DATE THEREOF 6/9/60										22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.										22d. LOCATION (City, town, or county) HAGERSTOWN MD.										(State)																																							
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md										ADDRESS										24a. REC'D BY REGISTRAR JUN 10 '60										24b. REGISTRAR'S SIGNATURE C. L. S. Hume																																																	

MEDICAL CERTIFICATION



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

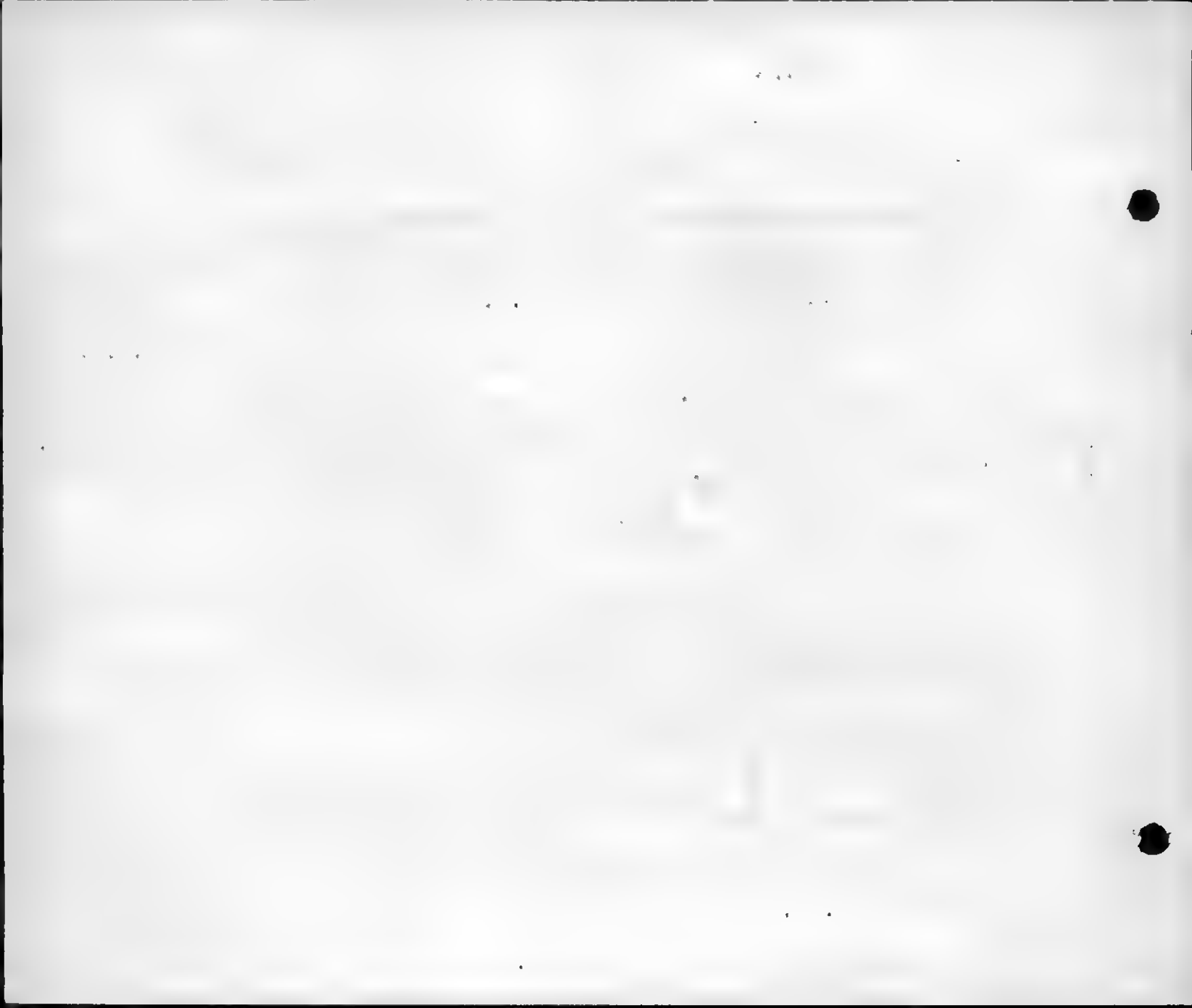
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15M 9/59

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7423  
7423  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07428

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Dianne</u> Last <u>Weller</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6.6.1960</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard J Weller Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta M Hose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Howard J Weller Jr</u>		Address <u>Rural 2 Hancock Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO (b) <u>Intestinal illness</u> DUE TO (c) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2d</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Immaturity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 June 1960</u> to <u>14 June 1960</u> , that (I) (we) last saw the deceased alive on <u>14 June 1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold H. Gist</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD H. GIST M.D.</u>		22d. ADDRESS <u>111 N. Potomac St. HAGERSTOWN MD.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6.15.60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Hancock Washington Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>		25a. REGISTERED BY REGISTRAR <u>Arthur S. Thomas</u>	
ADDRESS <u>Hagerstown Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

2081348XV0

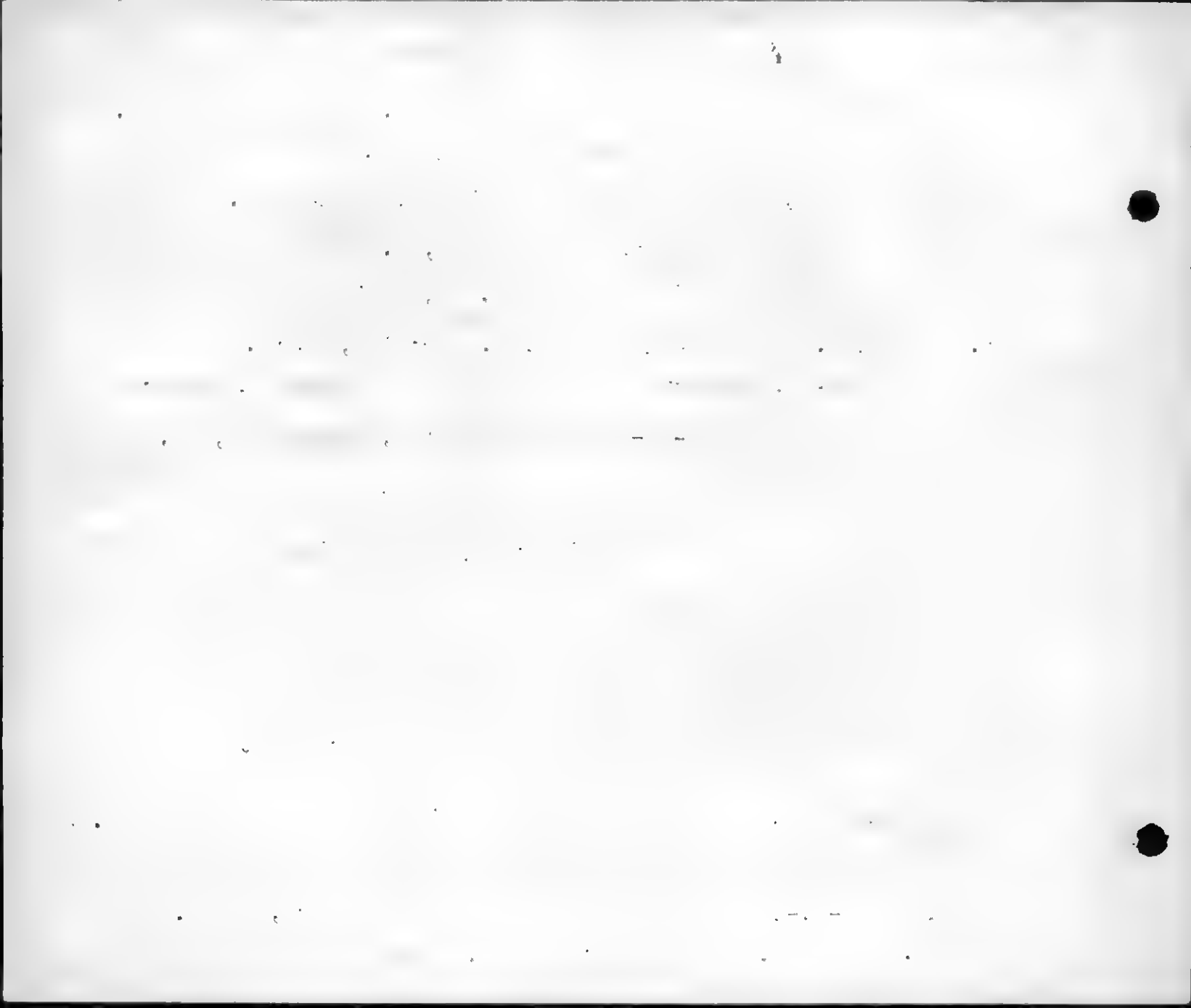




Reg. Dist. No. **07429**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>19 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> <b>Kenneth</b> <b>Wheeler, Sr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1901</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ex. Vice Pres.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>refrigeration Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Berwick, Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry C. Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Vernie Kingsbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>226-09-8024</b>	
17. INFORMANT <b>Wilba Wheeler, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Cerebral hemorrhage</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> (treated with Hys Hysine) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 yrs</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-14</b> , 19 <b>60</b> , to <b>6-15-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-15</b> , 19 <b>60</b> , and that death occurred at <b>6:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street city or town, state) <b>137 W. Washington</b> DATE SIGNED <b>6-15-60</b> ACTUAL SIGNATURE <b>Robert P. Conrad</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad, MD</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-18-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berwick, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hays</b>			

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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7425

Item in file 7-6-60 et

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>3 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u> d. STREET ADDRESS <u>Alms House</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert White</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Becraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of blood</u> DUE TO (b) <u>Carcinoma of the tongue</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1960</u> to <u>June 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1960</u> , and that death occurred on <u>June 20, 1960</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE SIGNED <u>June 21, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>6-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Bld. V. of Md.</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR <u>JUN 27 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>William E. Kiana</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. **07431**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Idia</b> Middle <b>Etta</b> Last <b>Wolfe</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Garfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Roman Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Laurah Kuhn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-18-1185</b>	
17. INFORMANT <b>Charles F. Wolfe, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Agranulocytosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Probable Aspirin Toxicity</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Wks.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/3</b> , 19 <b>54</b> , to <b>6/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/15</b> , 19 <b>60</b> , and that death occurred at <b>9:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>6/16/60</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.		DATE SIGNED <b>6/16/60</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>		Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-19-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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